Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Account 2025/2026

Contents

Our mission, vision, aims and values

Warrington and Halton Teaching Hospitals have been working alongside Bridgewater Community Healthcare with the aim to successfully integrate the two organisations to become one, North Cheshire and Mersey NHS Foundation Trust.

Looking ahead, our future strategic vision, mission and aims as one organisation will also be refreshed. Our interim mission is to be exceptional for our patients, our communities and each other. Our vision is to be a great organisation providing excellent healthcare and opportunities to work and learn. Our aims focus on quality, people and sustainability, always putting patients first, being the best place to work and working in partnership to improve health equity.

By the end of next year, the Trust will update its vision, mission and aims through continued engagement with staff, patients and communities. This shared approach reflects our commitment to ensuring that the organisation's direction is shaped by those who work in and rely on our services.

Our Strategic Quality Aim 2025/26

The Trust has remained focused during 2025/26 on the delivery of the Strategic Quality Aim, which is linked to the achievement of the following three Strategic Objectives:

- **Patient Safety,**
- **Clinical Effectiveness**
- **Patient Experience**

Part 1

A Statement on Quality from the Chief Executive

and

Introduction from the Chief Nurse and Executive Medical Director

1.0 A Statement on quality from the Chief Executive, Nikhil Khashu

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) share a collective commitment to delivering high-quality care, clinical excellence, and an outstanding experience for our patients, families, and staff. As two organisations serving broadly the same population, we recognise the significant opportunity and responsibility we have to work together to shape a sustainable, high-performing, and integrated health and care system for our communities.

Both organisations currently contribute different but complementary expertise across the acute, secondary, and community care pathways. By bringing our services together, we can enhance health outcomes, improve the quality and consistency of patient care, and strengthen the long-term clinical and financial sustainability of local services. Put simply, we want to provide better care together, and we are committed to doing so as swiftly and effectively as possible.

Our combined workforce of more than 6,700 colleagues serves a population of over 330,000 people from 75 locations, supported by a combined turnover of approximately £0.5bn. To meet the growing demands of an ageing and increasingly complex population, we must continue to innovate and adapt how, where, and when services are delivered. Integration provides an unprecedented opportunity to redesign pathways, reduce duplication, and address current system pressures—while ensuring that patients receive quality care that is timely, seamless, and centred around their needs.

We acknowledge the broader pressures facing the NHS nationally: rising demand, constrained workforce supply, and financial challenges. Locally, issues such as patient flow and acute bed occupancy often driven by patients who no longer meet hospital residency criteria—require collaborative, system-wide solutions. We will continue to work closely with our partners, taking shared responsibility for those under our care and striving to deliver services that reflect the highest standards of quality, safety, clinical effectiveness, and patient experience.

The Quality Account provides an important opportunity to reflect on achievements, performance, and learning across the year. We are proud of the progress made against our quality priorities during 2025/26 and the strong governance mechanisms that support transparency, assurance, and continuous improvement. Our priorities for 2026/27 build upon national and local drivers, robust internal intelligence, and extensive engagement with patients, families, staff, and stakeholders including insights from the Patient Equality, Diversity and Inclusion Sub Committee and our Experts by Experience.

Our three domains of quality remain fundamental to our work:

1. **Patient Safety** – Strengthening our safety culture and embedding practices that make safe, high-quality care the responsibility of every colleague.
2. **Clinical Effectiveness** – Ensuring that care is evidence-based and consistently delivered in the right way to achieve the right outcomes.
3. **Patient Experience** – Placing the individual at the heart of every interaction, ensuring care is compassionate, personalised, and respectful.

Comments received from stakeholders on the content of the Quality Account are included verbatim in full in Annex 1 of this report. We welcome continued engagement as we refine the opportunities ahead and work together to design an integrated acute and community healthcare system that delivers excellence for the people we serve.

To the best of my knowledge, the information presented reflects an accurate and balanced account of our performance and our ambitions for the future. I am immensely proud of what we have achieved as a Trust and as part of the wider health and care system, and I look forward to the next stage of our shared journey

Nikhill Khashu
Chief Executive

June 2026

1.1 Introduction from Ali Kennah, Chief Nurse and Paul Fitzsimmons, Executive Medical Director

At Warrington and Halton Teaching Hospitals NHS Foundation Trust, we remain firmly committed to fostering a culture of continuous quality improvement one where the voices of our patients and our people actively shape the care we deliver.

Central to this commitment are our *Five Essentials of Continuous Quality Improvement*:

- **Understand**
- **Define**
- **Develop**
- **Test**
- **Embed**

These essentials provide a strong and reliable framework to guide improvement, drive innovation, and ensure that positive change is both meaningful and sustainable. When combined with our wider programmes including the Patient Safety Incident Response Framework (PSIRF) and the Trust's culture programme work they enable us to strengthen our patient safety, learning, and improvement culture at every level.

The implementation of PSIRF continues to progress successfully, supported by new tools, enhanced methodologies, and a system-thinking approach to learning. Working closely with our patient safety partners and subject matter experts ensures that our learning is richer, our actions more effective, and our services safer for the communities we serve. Alongside this, our continued focus on nurturing a research-active workforce is helping us not only improve care today but also contribute to the longer-term health and wellbeing of our population.

We are immensely proud of the dedication, resilience, and professionalism demonstrated across the Trust, particularly during a period when healthcare organisations nationwide continue to face significant operational challenges. As leaders, we remain committed to guiding the organisation with clarity, ambition, and purpose as we work towards achieving an 'Outstanding' rating for the care we provide.

This year, staff across the Trust have delivered tangible improvements across the quality agenda, reflecting the strength of our collective commitment. As we transition to become the North Cheshire and Mersey NHS Foundation Trust, we will continue to build on this momentum strengthening our culture, improving outcomes, and ensuring the best possible experience for our patients and their families.

Ali Kennah
Chief Nurse

Paul Fitzsimmons
Medical Director

Part 2

Priorities for Improvement and Statements of Assurance from the Board of Directors

WHAT IS A QUALITY ACCOUNT?
Quality Accounts are annual reports to the public about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to defining our priorities for the next year to indicate how we plan to achieve these, and quantify their outcomes.

2.0 Priorities for Improvement and Statements of Assurance from the Board of Directors.

This section details:

- **How we will monitor, measure and report on Quality Priorities to achieve our priorities for quality improvement.**
- **Looking back - A review of the Quality Priorities that were agreed during 2025/26.**
- **Performance against the agreed Quality Priorities for 2025/26.**
- **Information regarding the Statements of Assurance which is mandatory text that all NHS Foundation Trusts must include in their Quality Account.**

A programme of work was established that corresponded to each of the quality improvement areas targeted. Each individual scheme within the programme has contributed to one, or more, of the overall performance targets set by Warrington and Halton Teaching Hospitals, NHS Foundation Trust. Considerable progress and improvements have been delivered through the commitment of staff to influence and sustain improvements.

Comparative performance benchmarked data.

Wherever applicable, the Quality Account will refer to performance in previous years and comparative performance benchmarked data with other similar organisations. This will assist in understanding progress over time and is a means of demonstrating performance compared to other organisations. This will help to add context to the data provided. Wherever possible, references to the data sources for the quality improvement indicators/priorities will be stated within the body of the report or within the Glossary of Abbreviations and Glossary of Terms, including whether the data is governed by national definitions.

Organisational Structure - How we will monitor, measure and report on-going progress to achieve our priorities for quality improvement.

The Trust's organisational structure enables Warrington and Halton Teaching Hospitals NHS Foundation Trust to be responsive to challenges through effective clinical engagement, with strong and resilient leadership at all levels to deliver the best outcomes for patients. This is achieved through a variety of methods, including continuous quality improvement, transformation, research and innovation.

The structure was developed collaboratively with stakeholders to deliver care and services using a 'Care Group' model, which consists of various clinical specialties within a Clinical Business Unit (CBU) structure. There are four Care Group structures at Warrington and Halton Teaching Hospitals NHS Foundation Trust: Planned Care, Unplanned Care, Clinical Support Services and Corporate Services. The operational Care Groups work with a triumvirate leadership model to deliver a high-quality and cost-efficient service. Warrington and Halton

Teaching Hospitals NHS Foundation Trust has seven Clinical Business Units, which are responsible and accountable to the relevant Care Groups. These report through to the appropriate senior team and the Executive Directors.

The Trust's organisational structure embraces the concept of compassionate leadership, with the triumvirate model bringing together a wealth of knowledge and expertise among senior doctors, senior nurses/allied health professionals and senior managers, all of whom work collaboratively to ensure efficiencies across clinical, quality, operational and financial requirements.

The information presented in the Quality Account represents information from the Clinical Business Units, supported by Corporate Services which has been monitored over the last 12 months by the Patient Safety and Clinical Effectiveness Sub Committee, Quality Assurance Committee, Council of Governors, Trust Board of Directors, and the Integrated Care Board (ICB).

2.1 Looking Back - Performance against Quality Priorities for 2025/26.

The following Quality Priorities were identified and agreed for implementation in 2025/26. These are referenced in accordance with the three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience.

Throughout the year the progress on each Quality Priority for 2025/26 is reported and monitored on a quarterly basis to the Trust's Patient Safety and Clinical Effectiveness Sub Committee, Quality Assurance Committee. Council of Governors, Trust Board of Directors, and the Integrated Care Board.

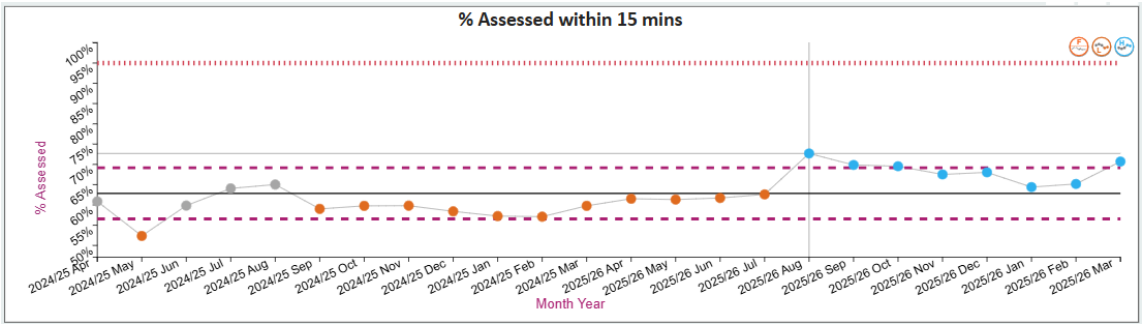
2025-26 Quality Priorities

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

The improvement aims	Description of Quality Priorities	The outcome
Improve patient safety	1. Ensure that all patients within the Emergency Department (UEC) receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes. 2. Improve access and productivity in elective care as per national operational planned guidance. 3. We will use quality improvement methods to improve provision of harm free care to our patients with a focus on preventing and reducing harms from pressure ulcers, malnutrition, and sepsis.	**Patient safety is enhanced through a learning culture where quality and safety is everyone's top priority**
Improve patient experience	4. Reduce Health Inequalities inline with CORE20+5 for Children, Adults and Young People. 5. Improve the experience and care provided for patients with a Learning Disability and impaired Mental Health. 6. Implementation of Accessible Information Standard relating to communication and reasonable adjustments to improve Patient Experience	**Practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients**
Improve clinical effectiveness	7. Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIFRT recommendations to support timelier and more effective patient care. 8. Reduce Cancer Waiting Times 9. Improve Theatre Safety Culture using whole quality system approach and robust governance process.	**The quality of the patient experience is at the heart of all we do and 'seeing the person in the patient' is the norm**

Quality Priorities for 2025/26 and the information below contains an update on progress on each of the Quality Priorities under the three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience.

Patient Safety

Patient Safety - We are committed to developing and enhancing our patients' safety through a learning culture where quality and safety is everyone's top priority.
1. Ensure that all patients within the Emergency Department (UEC) receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes. **Leads:** Sharon Kilkenny, Associate Director of Unplanned Care / Dr Mark Forrest, Clinical Director for Unplanned Care
What success will look like
Objective 1: Beginning – Triage: 70% of patients attending the Emergency Department, Urgent Treatment Centre and Same Day Emergency Care to have an MTS (Manchester Triage Score) triage within 15 minutes. **Objective 2: Middle – Main Department:** To develop and implement a method for all speciality response times to be measured. **Objective 3: End – Acute Medical Unit / Discharge:** To increase Hot Clinic capacity across Respiratory and Gastroenterology.
Q4 progress/summary
Have all measures/monitoring been achieved  • The Trust achieved the trajectory in the last month of quarter 4 with 70.69% of patients receiving their initial assessment across type 1, Emergency Department (ED), type 3, Urgent Treatment Centre (UTC) and type 5, Same Day Emergency Care (SDEC) within 15 minutes of arrival. • Type 1 (ED) performance in March 2026 was 67.24%, type 3 (UTC) was 78.11% and type 5 (SDEC) was 72.85%. Type 1 accounts for the Trusts sickest patients arriving in the hospital. The metric remains challenged for type 1 patients due to ambulance handover times being greater than 15 minutes. • Performance is being monitored through the weekly Care Group Key Performance Indicator Group where any deviations from the trajectory can be quickly identified and a plan for correction agreed.

Improvement outcomes

- The Trust has seen sustained improvement for quarter 4 despite the ambulance handover challenges with type 3 and type 5 both exceeding the 70% trajectory.

Key Learning

- The Triage Team has been established and have implemented a new triage pathway which integrates streaming to other areas of the Trust. This is based on models observed at other Trusts and aims to ensure that patients are seen in the most appropriate location for their care needs, as quickly as possible. Surgical SDEC was opened as a test of change towards the end of February 2026 which supported the improvement in Type 1 triage times in March 2026.
- Opportunities for discussion with the multi-disciplinary team (medical staff, nurses, advanced clinical practitioners, administrative colleagues, operational teams and transformation) has resulted in the identification of several opportunities for improvement in the triage pathway.

Objective 2: Middle – Main Department: To develop and implement a method for all speciality response times to be measured.

Have all measures/monitoring been achieved

- A method for all specialty response times has been developed using the e-outcome system.
- This is not fully rolled out to planned care specialties currently but has been adopted by The Acute Medicine Specialty, Surgery, Ears Nose and Throat (ENT) and Urology.
- Specialty “wait to be seen times” are monitored at site meetings daily (Monday to Friday).
- The Associate Medical Director and Clinical Directors within Planned Care are implementing the system within the Care Group for Trauma and Orthopaedics, Gynaecology and Paediatrics.
- The Associate Medical Director for Clinical Effectiveness and Business Information Team are developing a dashboard to monitor specialty wait to be seen times.

Improvement outcomes

- The dashboard is expected to go live in Quarter 1 of 2026/2027. Manual reporting via e-outcome continues via the bed meeting in the interim.

Key Learning

- The oversight of specialty response times enables teams to flex the workforce available to reduce waiting times.

Objective 3: End – Acute Medical Unit/Discharge: To increase Hot Clinic capacity across Respiratory and Gastroenterology.

Have all measures/monitoring been achieved

- Hot clinics within Acute Medicine and Surgery are operational and run through the Same Day Emergency Care unit.

- Hot clinics in Gastroenterology, Cardiology, Respiratory and Diabetes and Endocrinology went live in quarter 3 with metrics being monitored through Clinical Quality Oversight Group (CQOG). These were discontinued due to limited demand.
- It was established that a number of specialties already had urgent pathways set up within their out-patient set up to see urgent patients – Cardiology, Respiratory and Gastroenterology.

Improvement outcomes

- Greater awareness of urgent pathways in out-patients to support a reduction in admissions and to reduce time in the Emergency Department.

Has this Priority been achieved	Actions being taken
Action on schedule or ongoing	• Continue to embed the Trust triage and streaming pathways across Type 1 (ED), type 3 (UTC) and type 5 (SDEC) pathways. • Utilise the "wait to be seen" monitoring system (e-outcome whilst the dashboard is developed to inform improvement opportunity. • Continue to promote awareness of speciality hot clinic slots across Gastroenterology, Cardiology and Respiratory to support early supported discharge and admission avoidance.

QP2: Improve access and productivity in elective care as per national operational planning guidance.

Lead: Zoe Harris, Director of Operations and Performance, Deputy Chief Operating Officer/Sharon Kilkenny, Associate Director of Unplanned Care/Hilary Stennings, Associate Director of Clinical Support Services

What success will look like

Objective 1: Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026

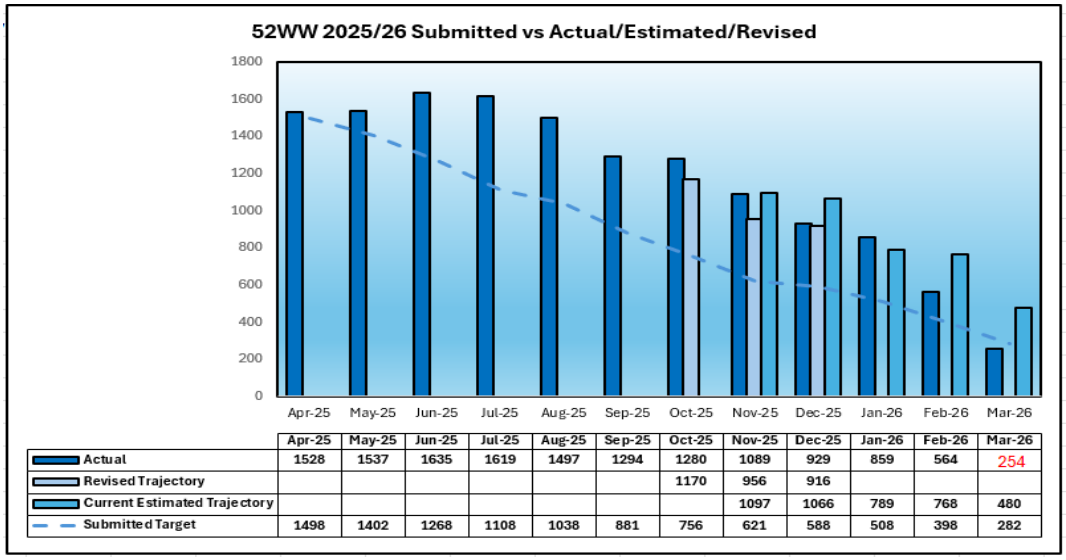
Q4 progress/summary

Objective 1: Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026

Have all measures/monitoring been achieved

- The Trust has delivered the standard of less than 1% of patients waiting over 52 weeks and is forecasting 0.77%.

Improvement outcomes



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Actual	1528	1537	1635	1619	1497	1294	1280	1089	929	859	564	254
Revised Trajectory							1170	956	916			
Current Estimated Trajectory								1097	1066	789	768	480
Submitted Target	1498	1402	1268	1108	1038	881	756	621	588	508	398	282

Key Learning

- To continue to revise plans to meet any unexpected challenges.

	Actions being taken
Action on schedule or ongoing	• This priority has been achieved.

<u>QP3: We will use quality improvement methods to improve provision of harm free care to our patients with a focus on preventing and reducing harms from pressure ulcers, malnutrition, and sepsis.</u>
Lead: Emma Hackett, Associate Chief of Nursing for Corporate Services/Sonia Griffin, Associate Chief Nurse for Planned Care/Imogen Lyons, Head of Continuous Quality Improvement

What success will look like

Objective 1: MUST - Improve the compliance with the Nutritional Assessment of Adult inpatients utilising the Malnutrition Universal Screening Tool (MUST). The overall target of the Trust is to achieve 95% compliance with assessment being completed within 24 hours of admission and then as a minimum every 7 days during their inpatient stay. With an aim to improve on current compliance in both metrics by 25% this year and to provide assurance that the appropriate level of intervention is provided to support patients in relation to their assessed needs and improve clinical outcomes.
Objective 2: Pressure Ulcers - Reduce the number of Category 2 pressure ulcers by 20% with zero tolerance of Category 3 and Category 4 pressure ulcers.
Objective 3: Sepsis - To achieve 85% compliance with Sepsis six and the completion of the Sepsis Tool by March 2026.

Q4 progress/summary

Objective 1: MUST - Improve the compliance with the Nutritional Assessment of Adult inpatients utilising the Malnutrition Universal Screening Tool (MUST). The overall target of the Trust is to achieve 95% compliance with assessment being completed within 24 hours of admission and, as a minimum every 7 days during the inpatient stay. The Trust also aims to

improve on current compliance in both metrics by 25% this year and provide assurance that the appropriate level of intervention is provided to support patients in relation to their assessed needs and improve clinical outcomes.

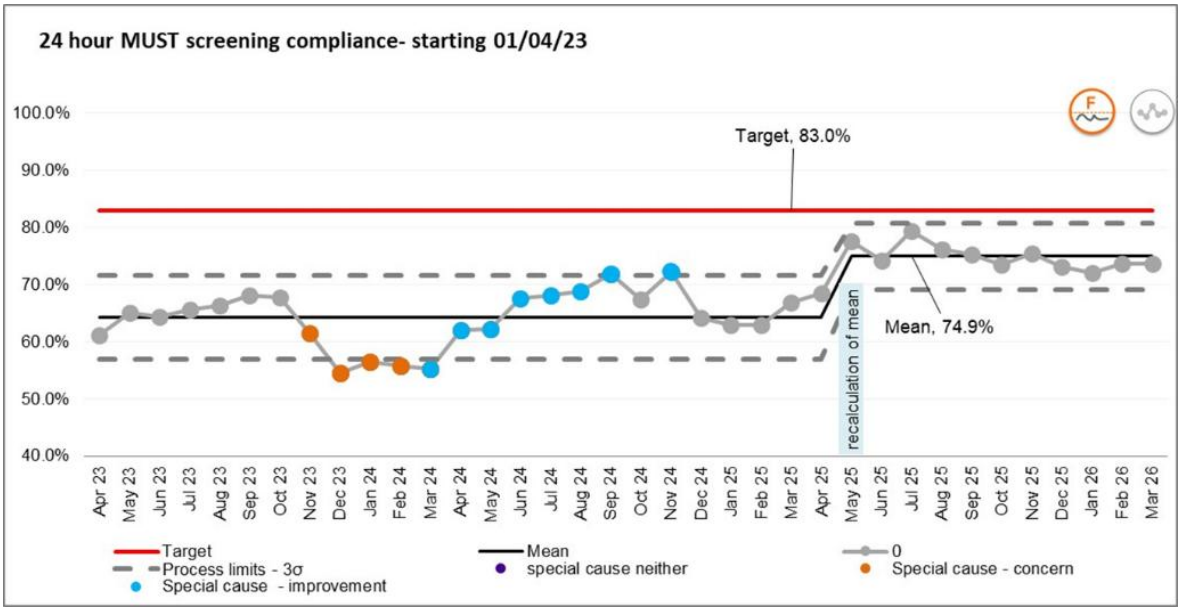
Have all measures/monitoring been achieved

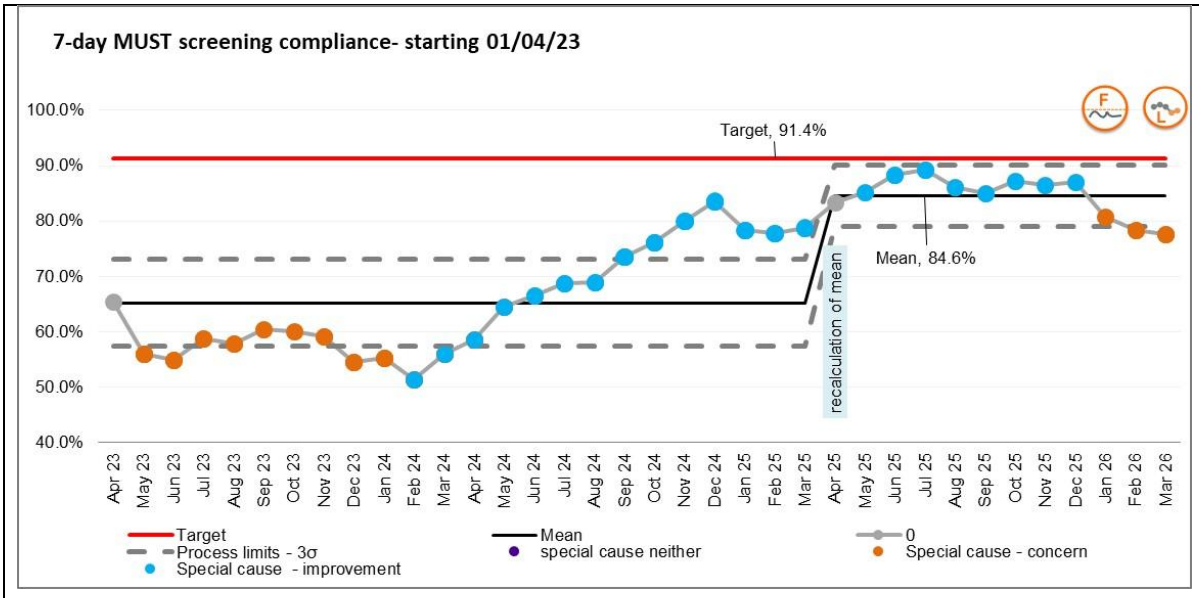
- Compliance across both measures has dropped in Quarter 4 compared to previous quarters, this remains within expected variation for the 24-hour standard but demonstrates a significant deterioration in 7-day compliance.
- Overall, screening within 24 hours and 7 days has increased by 12 and 13% respectively in 2025/26 compared to the previous 12 months. However, the 25% aim has not been achieved.

Measures	Baseline 2024-25	Aim (↑25%)	Q1 2025-26	Q2 2025-26	Q3 2025-26	Q4 2025-26
% with MUST <24hrs from admission	66.4%	83.0%	73.4%	77.0%	74.0%	73.4%
% 7-day compliance	73.1%	91.4%	85.6%	86.7%	86.9%	78.9%

Improvement outcomes

- The charts below show that the improvements seen in 24-hour compliance with the Malnutrition Universal Screening Tool (MUST) screening in the first 3 quarters of the year have dropped slightly but remain within expected variation.
- Compliance with 7-day screening shows a significant deterioration during quarter 4.





Key Learning

- All Clinical Business Units submit quarterly high-level briefing papers (HLBP) to provide assurance of ongoing work to improve malnutrition screening.
- The Nutrition, Food and Hydration Steering Group meets monthly.
- To continue sharing individual wards quality improvement work to support learning and implement changes Trust wide to prevent local variation.

Objective 2: Pressure Ulcers - Reduce the number of category 2 pressure ulcers by 20% with zero tolerance of category 3 and category 4 pressure ulcers.

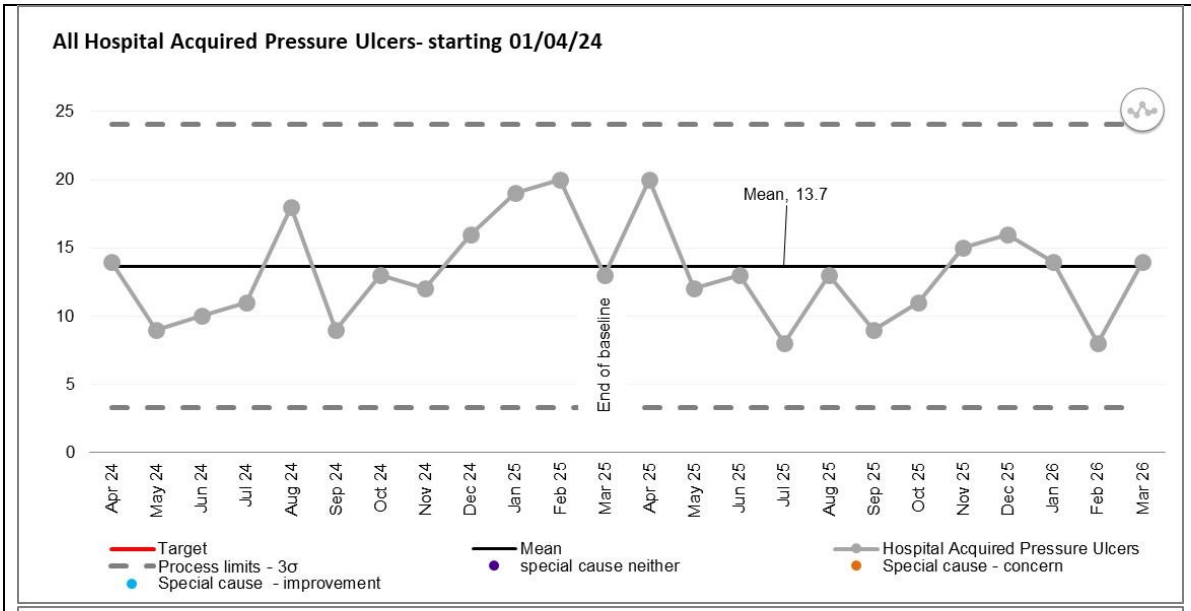
Have all measures/monitoring been achieved

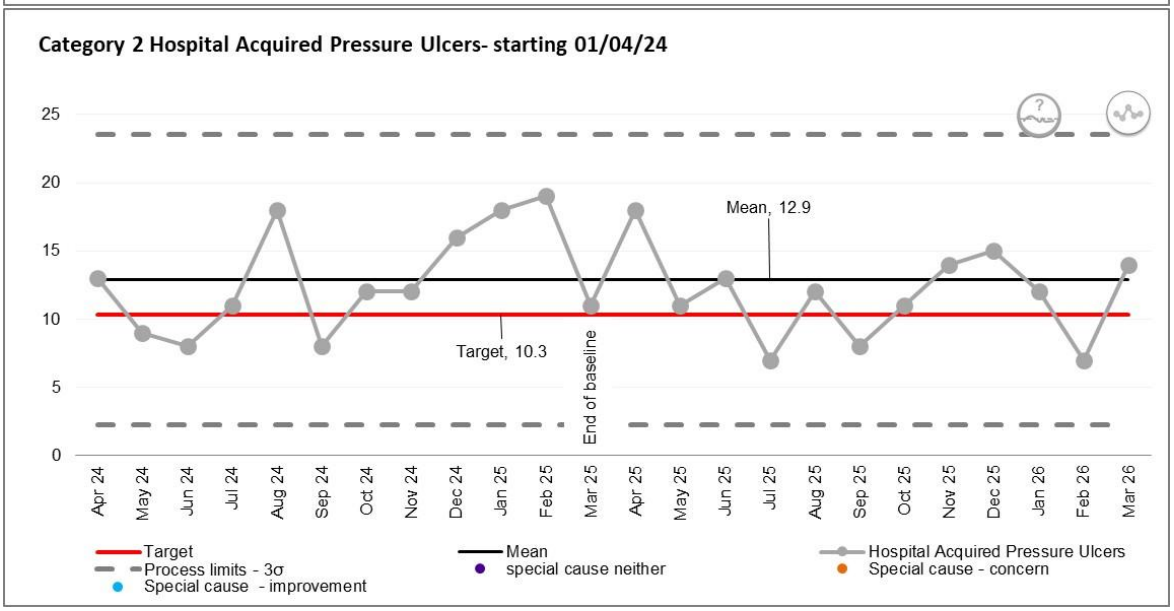
- There was a 7% reduction in the overall number of pressure ulcers in the 12 months to March 2026, compared to the previous 12 months. This equates to 11 fewer patients harmed. This is consistent with normal variation and the aim to reduce the number of category 2 pressure ulcers by 20% with zero tolerance of category 3 and category 4 pressure ulcers has not been achieved by March 2026.
- Three category 3 pressure ulcers were recorded during quarter 4.

Measures (monthly average)	Baseline 2024-25	Aim (↓20%)	Q1 2025-26	Q2 2025-26	Q3 2025-26	Q4 2025-26
Category 2 HAPU	**12.9**	10.3	14	9	13	11
Category 3 HAPU	**0.5**	0	0.7	0.3	0.7	1
Category 4 HAPU	**0**	0	0	0.3	0	0

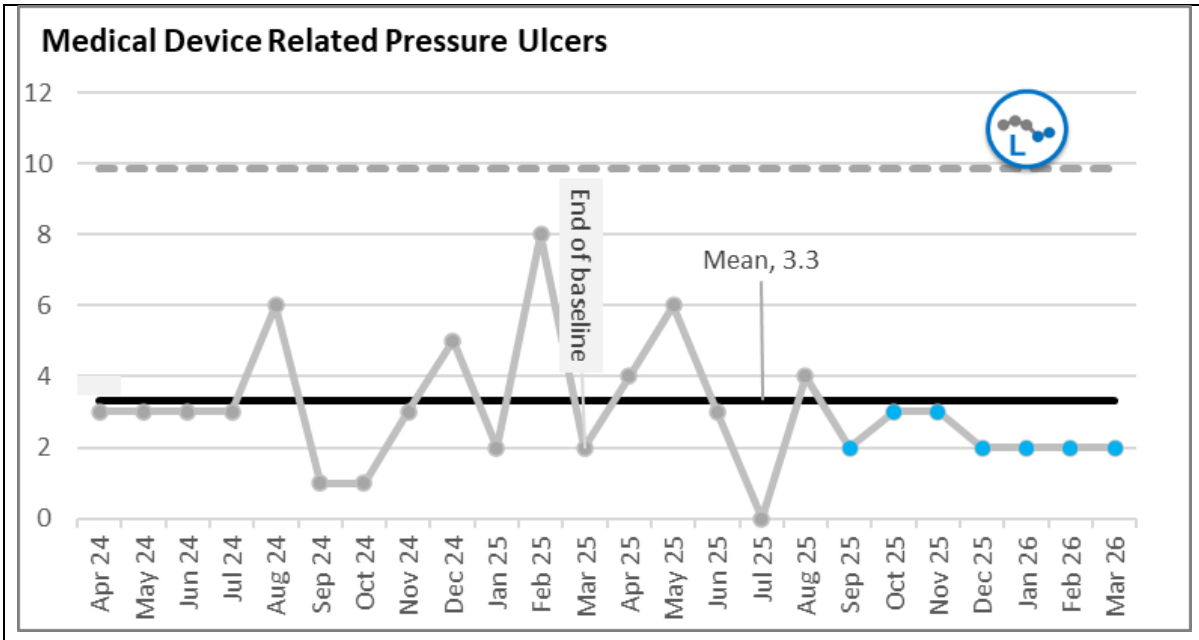
Improvement outcomes

- The reduction in the number of hospital acquired pressure ulcers (HAPU) observed in quarter 2 has not been sustained in quarters 3 and 4. This remains within normal variation. The aim is not being consistently achieved.





- The chart below shows special cause improvement in the number of medical device related pressure ulcers since September 2026. This is likely a reflection of improvements in The Intensive Care Unit (ICU) over the same period.



Key Learning

- Two learning sessions were scheduled as part of the Harm Free Care Collaborative during quarter 4. The first was cancelled due to poor attendance on the day. The final learning session took place in March 2026 although only three wards were represented (A4, B18, ICU).
- While engagement in the collaborative has been inconsistent across wards, positive feedback was received on the opportunities for learning from each other, as well as the focus on engaging the wider ward team and different bands.

Objective 3: Sepsis - To achieve 85% compliance with Sepsis Six and the completion of the Sepsis Tool by March 2026.

Quarter 4 sepsis performance can be seen in the tables below.

Emergency Department (ED) sepsis key performance indicator overview - Quarter 4

Key performance indicator	January	February	March
Blood cultures within 1 hour	76%	74%	55%
Lactate within 1 hour	86%	86%	76%
Antibiotics prescribed within 1 hour	72%	71%	67%
Antibiotics administered within 1 hour	60%	55%	54%
Clinician review within 30 mins	56%	60%	42%
Senior review within 1 hour	56%	62%	64%
Was sepsis tool used?	47%	45%	40%
NEWS within hour of arrival to hospital	88%	95%	79%
IV fluids within hour (systolic below 90 or lactate 2+)	70%	79%	50%

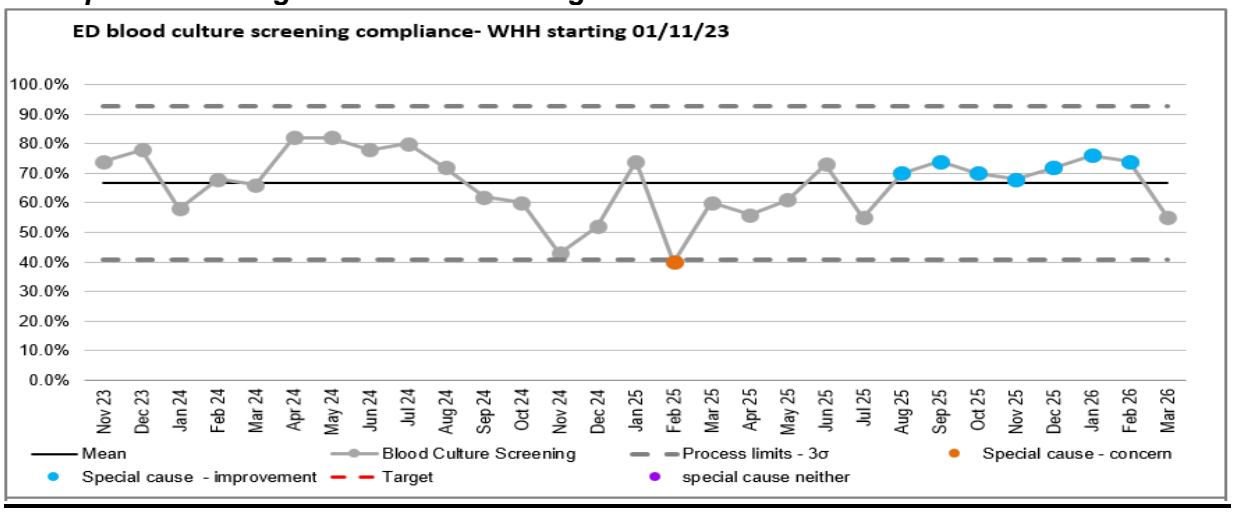
Inpatient sepsis key performance indicator overview - Quarter 4

Key performance indicator	January	February	March
Blood cultures within 1 hour	80%	93%	88%
Lactate within 1 hour	92%	93%	64%
Antibiotics prescribed within 1 hour	96%	71%	76%
Antibiotics administered within 1 hour	88%	79%	68%
Clinician review within 30 mins	84%	93%	93%
Senior review within 1 hour	44%	93%	64%
Was sepsis tool used?	24%	7%	16%
NEWS within hour of arrival to hospital	n/a	n/a	n/a
IV fluids within hour (systolic below 90 or lactate 2+)	79%	93%	68%

Emergency Department data

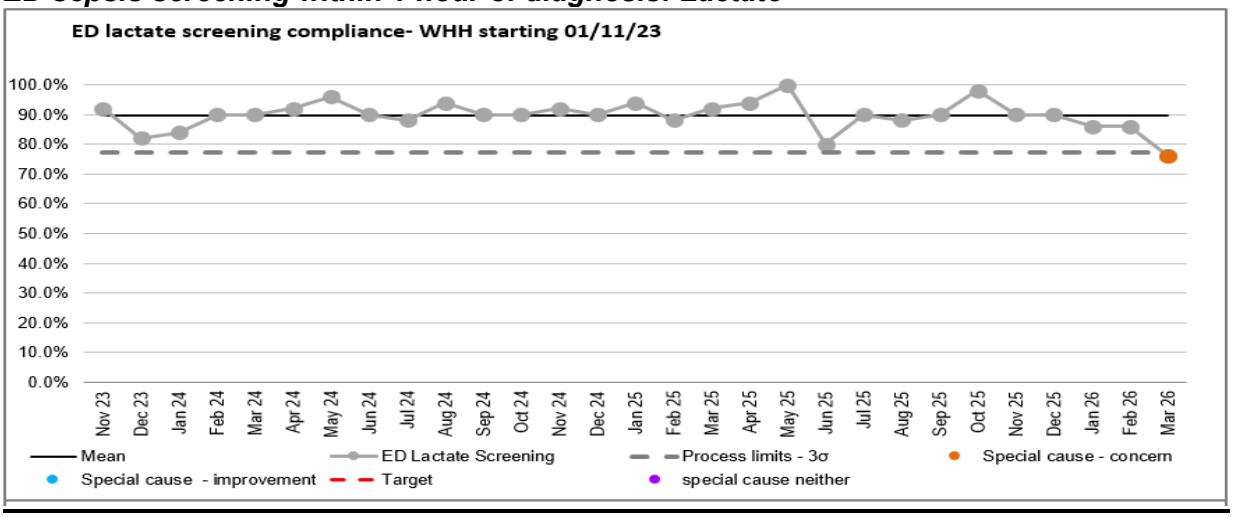
- The chart below shows the percentage of patients who had blood cultures taken within 1 hour in the Emergency Department (ED) in March 2026 is 55%. This is a reduction in compliance compared to that seen throughout quarter 3 and the rest of quarter 4. Blood Culture compliance within 1 hour had stabilised since August 2025 at circa 71-76% until March 2026.

ED sepsis screening within 1 hour of diagnosis: Blood Cultures



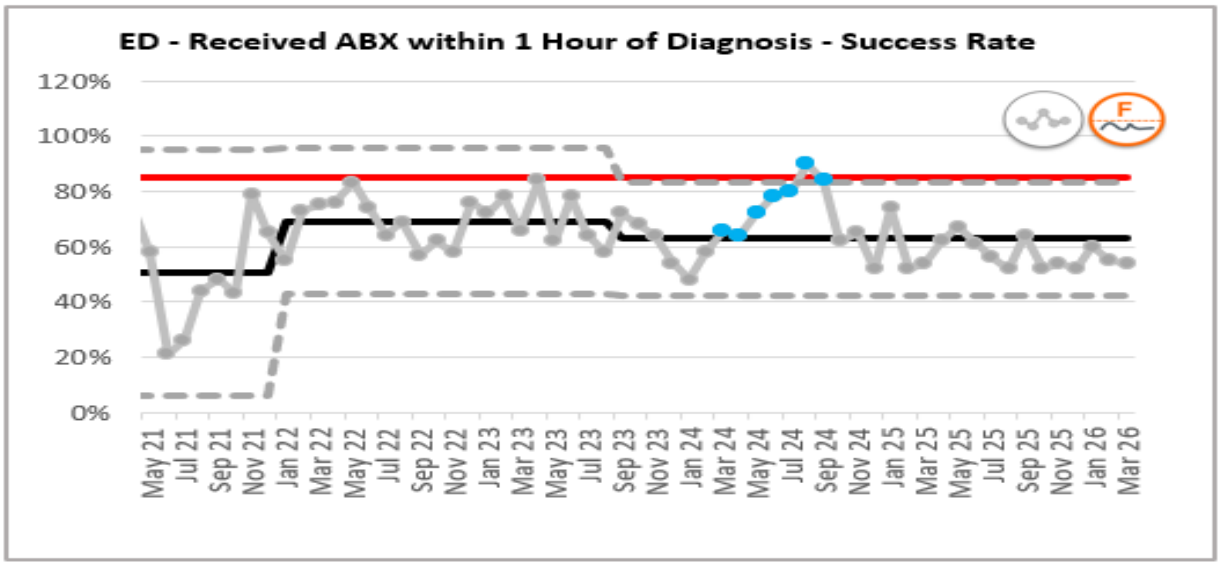
- The chart below shows the percentage of patients who had a lactate taken within 1 hour in the ED in March 2026 is 64%. This is a reduction in compliance compared to previous months.

ED sepsis screening within 1 hour of diagnosis: Lactate



- The chart below shows the percentage of patients in ED who received antibiotics within one hour in March 2026 is 54%. The Statistical Process Control (SPC) chart shows that there was special cause improvement until October 2024, when there was a change in the patients who were included in the data following the introduction of NICE Guidelines 51.

Percentage of ED patients who received antibiotics within 1 hour of sepsis diagnosis (April 2021 – September 2024) or within an hour from the NEWS2 score October 2024 onwards to reflect the new guidelines.

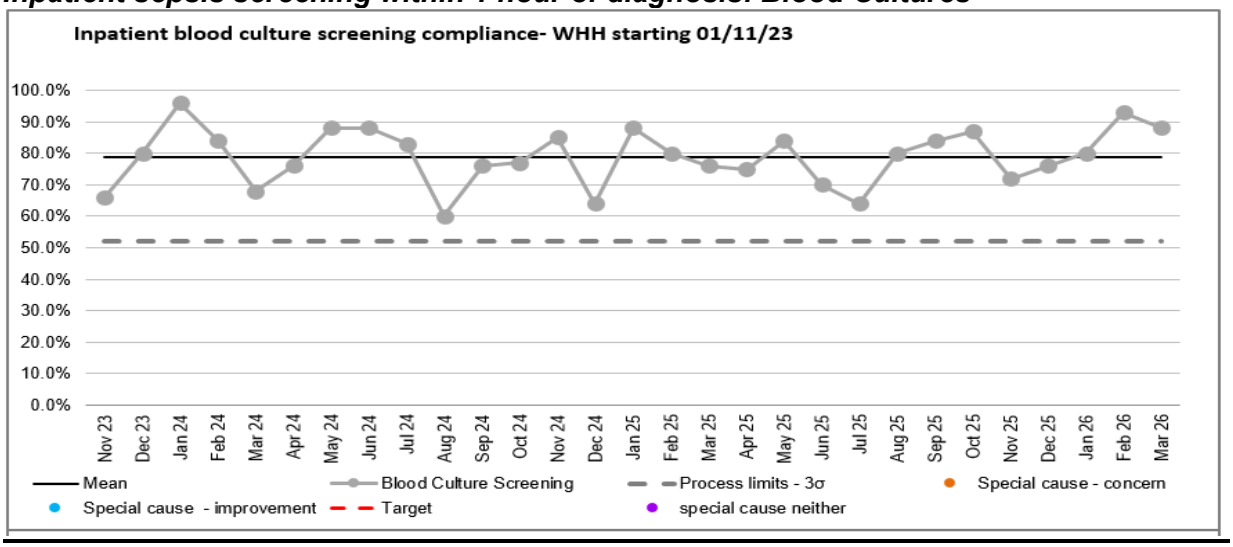


- The barriers for compliance of the sepsis metrics in ED include the number of patients presenting to the ED, patient acuity and the total number of patients within the ED. This has been particularly evident since October 2024 when NICE Guidance changed “Time zero” – the time that starts the 1-hour clock.

Inpatient Data

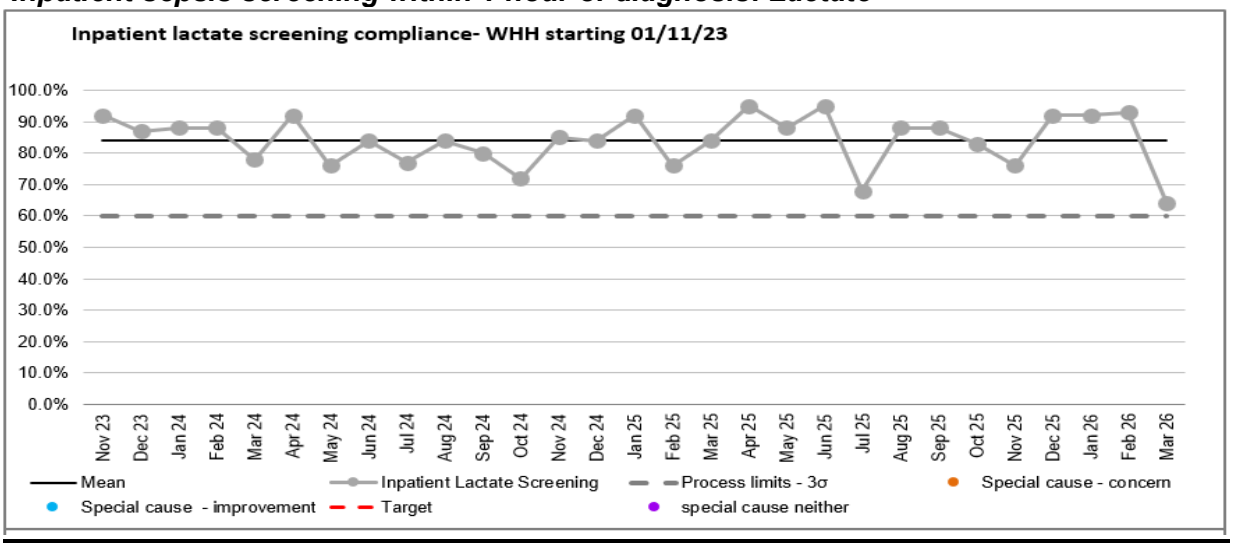
- The chart below shows the percentage of patients who had blood cultures taken within 1 hour for inpatient areas in March 2026 was 88%, which is within expected variation. There has been a trend towards increasing compliance over the last quarter. It is likely that this is due to the increase in the number of staff who are trained to take blood cultures.

Inpatient sepsis screening within 1 hour of diagnosis: Blood Cultures



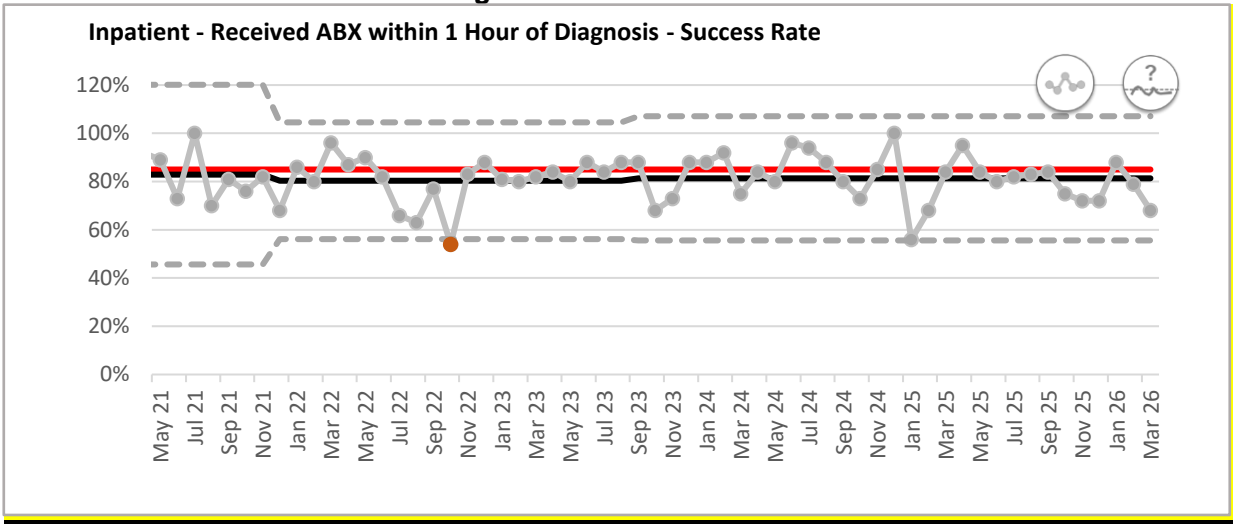
- The chart below shows the percentage of patients who had lactate taken within 1 hour for inpatient areas in March 2026 is 64%, which is a significant reduction compared to the previous 3 months.

Inpatient sepsis screening within 1 hour of diagnosis: Lactate



- The chart below shows the percentage of inpatients who received antibiotics within one hour in March 2026 is 68%, whilst this is within expected variation there has been a decline in performance during Quarter 4.

Percentage of Inpatients who received antibiotics within 1 hour of sepsis diagnosis (April 2021 – September 2024) and then October 2024 onwards, an hour from the NEWS2 score to reflect the new guidelines.



Key Learning

- An inpatient sepsis quality improvement (QI) project has been completed on Ward A4. The Patient Safety Improvement Nurses (PSIN) completed a sepsis process map on a surgical ward and identified barriers for both screening and antibiotic administration. PSINs worked with pharmacy colleagues and A4 Ward Manager to ensure that there is an adequate stock of antibiotics needed to support administration within the hour.
- The sepsis kits have been reintroduced on to 'My Kit Check' to provide assurance the Trust is providing the correct kit to ward staff for managing sepsis.
- The Medical Sepsis Lead for the Trust has completed sepsis teaching sessions for Resident Doctors and Consultants.
- During February 2026 the PSIN collected information on suspected source of sepsis and initial antibiotic given for inpatients. This has been shared with the pharmacy team and will support the Trusts work towards infection control and antimicrobial stewardship.
- A survey was set up allowing staff in ED to feedback their thoughts on barriers to antibiotic administration within the department. Results were shared with senior nursing and medical teams and will be used to inform the ED sepsis action plan.
- Engagement with the Acute Care Team to support inpatient sepsis performance.
- Increasing the number of staff who are trained to take blood cultures appears to be supporting improvements in blood cultures being taken within 1 hour for inpatient areas.
- There was a reduction in sepsis performance in ED across all metrics in March 2026. Work is underway with the team to understand the reasons for this so that learning and actions can be put in place to support improvements.

Has this Priority been achieved	**Actions being taken**
Action behind schedule with mitigation	**Objective 1:** All Clinical Business Units will submit a quarterly High Level Business Plan (HLBP) to provide assurance of ongoing activity to improve malnutrition screening. The Nutrition, Food and Hydration Steering Group meets monthly to oversee delivery and monitor progress.

	Mechanisms are in place to share ward-level quality improvement initiatives and learning, supporting the consistent implementation of good practice across the Trust and reducing unwarranted variation. **Objective2:** While engagement in the collaborative has been inconsistent across wards, positive feedback was received on the opportunities for learning from each other, as well as the focus on engaging the wider ward team and different bands. **Objective 3:** A new audit schedule has been proposed to commence in April 2026. This change focuses auditing and improvement efforts on the most impactful sepsis metrics, and most importantly those that will make the most significant impact on patient care. It has been agreed that the Sepsis Improvement Group will be merged into The Deteriorating Patient Group (DPG). This proposal has been made to ensure that there is Trust wide representation and therefore supporting a Multi-Disciplinary Team (MDT) approach to sepsis recognition and treatment, and learning, whist avoiding duplication. An MDT working group has commenced to address sepsis performance improvement in ED. This is being led by the Urgent and Emergency Care Lead Nurse and Clinical Director and overseen by the Associate Chief of Nursing for Corporate Nursing.

Patient Experience

Patient Experience: By focusing on patient experience, we want to place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.
QP4: Reduce Health Inequalities in line with CORE20+5 for Children, Adults and Young People. **Lead:** Thara Raj, Director of Population Health and Inequalities/Dr Sarika Raghunath, Consultant & Trust COPD Lead/Sonia Griffin, Associate Chief Nurse of Planned Care /Lucy Parry, Lead Nurse for Digestive Diseases, Ruth Heggie, Head of Learning and Organisational Development/Therapy Manager
What success will look like
Objective 1: To employ a health literacy approach: 1) Improving the quality of postal and digital invitation letters for all outpatient respiratory appointments and communications to patients about 'common' respiratory diseases like COPD and asthma and 2) reviewing the quality of digital apps on the ORCHA library on respiratory conditions ahead of them being incorporated into a planned local review of respiratory services. The learning will be shared across the Integrated Care Board (ICB) footprint and beyond. **Objective 2:** To re-establish a Tackling Tobacco Dependency service within the Trust that will deliver brief interventions with acute inpatients.

Objective 3: To develop a pool of trainers across North Cheshire and Mersey Healthcare Partnership who can cascade the Make Every Contact Count (MECC) for physical activity training within our respective organisations. Participants of the training will increase their knowledge, confidence and skills to be able to:

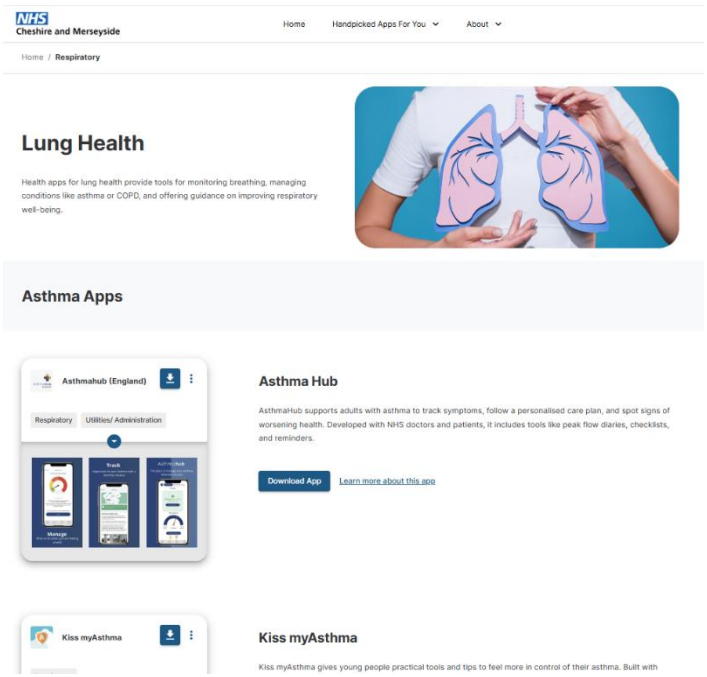
1. Identify the benefits of physical activity, and how to apply the Chief Medical Officer and NICE recommended Guidelines.
2. Define the MECC approach and explore how this can be applied to promote physical activity in health and social care services.
3. Be aware of local support services and how to effectively signpost patients to the appropriate support/referral pathways.

Q4 progress/summary

Objective 1: To employ a health literacy approach: 1) to improving the quality of postal and digital invitation letters for all outpatient respiratory appointments and communications to patients about 'common' respiratory diseases like COPD and asthma and 2) reviewing the quality of digital apps on the ORCHA library on respiratory conditions ahead of them being incorporated into a planned local review of respiratory services. The learning will be shared across the ICB footprint and beyond.

Have all measures/monitoring been achieved

- The quarter 4 deliverable relating to completion of the digital app review has been achieved, supporting the NHS ambition to transition from analogue to digital services.
- Twelve patient-facing respiratory apps from the ORCHA library (NHS Cheshire and Merseyside website) were selected and, in partnership with ORCHA, their accompanying descriptions were rewritten in plain language to improve accessibility for people with lower health literacy.



This workstream is now complete.
In addition, the following enabling actions have been delivered:

- Health literacy has been embedded within the Trust Accessible Information Policy to support consistent adoption across services.

- A short film promoting health literacy has been produced, featuring an Expert by Experience who helped shape the programme.
- Health literacy training has been rolled out across multiple Trust services to strengthen capability and support implementation.

Improvement outcomes

- The Trust now has 12 digital respiratory apps that have been reviewed and can be recommended to patients to improve lung health.
- The Trust has a communication tool (short film) that shows health literacy in practice which can inform the implementation of the accessible information and digital and health literacy policy.

Key Learning

- The Trust presented this programme of work to all Office for Health Improvement and Disparities (DHSC) staff.
- The Trust co-organised a health literacy workshop for senior leaders across Cheshire and Merseyside which was attended by 22 leaders. This helped spread the principles of health literacy across the Integrated Care Board footprint.

Small changes in communication create big gains in usability
Reviewing and rewriting the 12 ORCHA respiratory app blurbs showed that even well-designed digital tools become inaccessible when the accompanying text is unclear. Clearer language, simpler sequencing, and removing jargon made the apps meaningfully more usable for people with low health literacy.

Health literacy needs to be embedded in policy, not delivered as a one-off project
Incorporating health literacy into the Trust's Accessible Information Policy demonstrated that sustainable change requires governance, not just training. This ensures consistency across services and creates a mechanism for scaling the approach across Place.

Co-design with patients improves both insight and credibility
Working with Experts by Experience, including featuring one in the short film, provided real-world insight into how people interpret letters, apps, and instructions. It also increased staff buy-in because the learning was grounded in lived experience, not abstract theory.

Staff training is essential for adoption and spread
Rolling out health literacy training across multiple services showed that frontline staff want practical tools they can use immediately. Teach-back, plain-language techniques, and better structuring of information were consistently identified as helpful and time-saving.

Digital transformation fails without digital and health literacy
The review of respiratory apps highlighted that digital tools alone do not improve outcomes. People need clear explanations, simple navigation, and confidence to use them. Otherwise, digital becomes another barrier rather than an enabler.

Health literacy strengthens prevention and self-management
Clearer letters, digital content, and app descriptions all support earlier understanding and earlier action. This directly contributes to prevention, reduced avoidable demand, and care closer to home.

The approach is transferable across the ICB footprint
The process used, including baseline insight, co-design, rewriting content, embedding in policy, and training, is replicable across other pathways and places. This makes the work scalable and relevant beyond Respiratory Care.

Objective 2: To re-establish a Tackling Tobacco Dependency Service within the Trust that will deliver brief interventions with acute inpatients.

Have all measures/monitoring been achieved

- Measures have been achieved in all quarters including Q4.
- In Q1 posts were re-advertised; in Q2 posts were recruited to; in Q3 Induction was completed; and in Q4 approximately 40% of referred patients were seen by the service.

Improvement outcomes

- The ambition was to see 60% of referred patients; however, with the ability to only recruit one member of staff, it has not been possible to achieve this. Foundation Year 1 doctor capacity has supported this service however they are doing it as a learning exercise not as sustainable service delivery.
- The Trust have improved the initial assessment form that is undertaken when a patient is admitted and the number of assessments completed has increased.

Key Learning

A single-advisor model is not operationally viable
The service cannot meet expected coverage with only one Tobacco Dependency Adviser. This confirms the national learning: tobacco dependency treatment requires a minimum team model, not a lone practitioner supplemented by rotational trainees.

Reliance on Foundation Doctors is helpful for learning but unsustainable for delivery
FY1s add value for brief interventions, but their involvement is inconsistent, time-limited, and dependent on rotation. This reinforces that clinical trainees cannot be used as core workforce for a mandated service.

Systematic identification at admission is the biggest gap
Only 60% of patients are asked about smoking status on admission. This means the service is not failing at treatment, it is failing at case-finding. Without 100% screening, the service cannot reach the intended population.

Nicotine Replacement Therapy (NRT) is under-offered
A small proportion of identified smokers are offered NRT. This indicates a training and confidence gap among admitting staff, not a lack of patient need.

Improving the admission assessment form increased completion rates
This shows that small design changes in documentation can shift behaviour, but only when paired with staff awareness and accountability.

The service is clinically effective when patients are reached
Seeing 40% of referred patients with only one adviser demonstrates strong demand and good engagement, reinforcing the case for investment.

Workforce constraints directly limit impact
The gap between the ambition (60% coverage) and delivery (40%) is not due to poor performance, it is due to structural under-resourcing.

Tobacco dependency treatment is a core part of inpatient care, not an optional add-on
The learning reinforces that smoking cessation is a clinical intervention, not a lifestyle conversation. Embedding it requires workforce, training, and system prompts.

Data quality is a limiting factor
Incomplete smoking status recording means the service cannot accurately measure unmet need or demonstrate full impact. Improving data capture is essential for future evaluation.

The service is aligned with national priorities but needs investment to meet them
The work demonstrates strong progress but also highlights that national expectations cannot be met without appropriate staffing.

Objective 3: To develop a pool of trainers across North Cheshire and Mersey Healthcare Partnership who can cascade the MECC for physical activity training within our respective organisations. Participants of the training will increase their knowledge, confidence and skills to be able to:

1. Identify the benefits of physical activity, and how to apply the Chief Medical Officer and NICE recommended Guidelines.
2. Define the MECC approach and explore how this can be applied to promote physical activity in health and social care services.
3. Be aware of local support services and how to effectively signpost patients to the appropriate support/referral pathways.

Have all measures/monitoring been achieved

- There is a pool of 20 train the trainers in North Cheshire and Mersey
- 26 hospital based AHPs have completed the training to date (April 2026)
- A further 52 have future dates booked in.
- Our community colleagues included MECC (make every contact count) in their previous organisations induction with a compliance rate of 94%.

Improvement outcomes

- Staff are actively using the MECC approach in their daily clinical interventions and bringing learning and feedback from this to their team meetings.
- A repository of information is being finalised to support in onward signposting of community and third sector resources to support physical activity.
- Teams are also utilising ORCHA to support in providing information to patients

Key Learning

- Exploring the possibility of how we continue to roll out and evolve the training and learning from MECC as a new organisation, collaborating with new colleagues to share learning and set direction on our approaches for the next 12 months.

Has this Priority been achieved	Actions being taken
Action on schedule or ongoing	This priority has been achieved.

QP5: Improve the experience and care provided for patients with a Learning Disability and impaired Mental Health.
Lead: Katie Clarke, Head of Safeguarding Adults & Children

What success will look like

Objective 1: To achieve 90% (Age 16+) improved compliance in regard to the completion of the mental capacity assessment and best interest process.
Objective 2: To achieve 90% of patients (Adults/Children) diagnosed with a learning disability and or autism to be offered reasonable adjustments as per the Learning Disability policy.
Objective 3: Ensure 90% of patients (Adults /Children) with Learning Disability and or autism who are admitted have a Learning Disability specific discharge checklist completed.

Q4 progress/ summary

Objective 1: To achieve 90% (Age 16+) improved compliance in regard to the completion of the mental capacity assessment and best interest process.

Have all measures/monitoring been achieved

- Progress continues against this objective; however, the 90% compliance target has not yet been fully achieved.

Following the organisational integration, significant work has been undertaken to develop standardised Mental Capacity Act (MCA) processes across the newly integrated Trust. As part of this work:

- A new, single MCA policy has been developed to align expectations, definitions and standards across services. This is in the final stages for approval.
- A revised MCA training package has been created to reflect the updated policy, integration learning, and audit findings.
- Electronic MCA forms have been reviewed and updated to improve clarity, prompt completion of key MCA elements and strengthen evidence of lawful decision-making.

The updated electronic documentation is designed to better support:

- Decision and time-specific capacity assessments.
- Recording the reason capacity is in doubt.
- Practicable steps taken to maximise capacity.
- Best Interest decision-making (including options appraisal and least restrictive practice).
- Independent Mental Capacity Advisor (IMCA) consideration where statutory criteria are met.

A go-live date for the updated electronic MCA documentation is to be agreed, subject to final system testing and operational readiness. Until implementation is complete, compliance remains variable across services, reflecting differing legacy systems and practices.

Oversight of progress continues through The Safeguarding Committee, with assurance linked to policy implementation, training rollout and revised documentation rather than audit outcomes alone during this transitional period.

Improvement outcomes

Although the compliance target has not yet been met, meaningful system-level improvements have been delivered in Q4:

- **Standardisation post-integration.**
  The development of a single MCA policy and training package represents a significant step towards consistent, Trust-wide MCA practice. This reduces variation and provides clearer expectations for staff across all clinical areas.

- **Strengthened digital infrastructure.**
  The review and update of electronic MCA forms directly address audit-identified gaps, embedding prompts for:
    - Best Interest processes,
    - Least restrictive options,
    - IMCA consideration, and
    - Equality and protected characteristics.

These changes are expected to drive improved documentation quality once live.

- **Improved workforce capability through training redesign**
  The revised training package places stronger emphasis on:
    - Best Interest decision-making,
    - Practicable steps to maximise capacity,
    - Fluctuating capacity, and
    - Recording lawful decision-making.

This responds directly to learning from Q3 audits and integration findings.

- **Clearer pathway to sustained improvement**
  The alignment of policy, training and electronic documentation provides a coherent framework for future auditing and monitoring, supporting progression towards the 90% target.

Key Learning

- **System alignment is essential following integration.**
  Inconsistent documentation and practice cannot be resolved through audit alone. Aligning policy, training and digital systems is a prerequisite to achieving sustainable compliance.

- **Electronic prompts are critical enablers of lawful practice.**
  Staff knowledge alone is insufficient; documentation templates must actively guide Best Interest decision-making, IMCA consideration and recording of practicable steps.

- **Implementation timing is a key risk.**
  Until the updated electronic forms go live, assurance remains limited. Agreeing and delivering the go-live date will be critical to demonstrating measurable improvement in Q1/Q2 2026/27.

- **Training must be linked to practice change.**
  The revised MCA training must be supported by local leadership and embedded into induction, supervision and audit processes to ensure learning translates into improved documentation and decision-making.

Objective 2: To achieve 90% of patients (Adults/Children) diagnosed with a learning disability and or autism to be offered reasonable adjustments as per the Learning Disability policy.

Have all measures/monitoring been achieved

- There has been no significant change in performance or assurance since Q3 against this objective, and the 90% compliance target has not yet been fully achieved.
- Existing systems to identify patients with a learning disability and/or autism, and to offer reasonable adjustments, remain in place and operational. These include electronic flagging, use of hospital passports, MDT planning and established reasonable adjustment practices across inpatient services. However, persistent issues with consistent documentation and variable recording of reasonable adjustments continue to limit evidenced compliance, particularly across outpatient and community pathways.
- During Q4, activity has focused on maintaining current standards and raising awareness of Learning Disability and Autism training, rather than introducing new monitoring mechanisms or audits.

Improvement outcomes

While no new improvement outcomes have been formally identified this quarter, the following activity continues to support progress towards the objective:

- **Sustained operational practice.**
  Reasonable adjustments continue to be offered in practice across many clinical areas, supported by electronic alerts, hospital passports and MDT discussion. This provides a stable baseline on which further improvement can be built.

- **Ongoing focus on workforce awareness**
  Work continues to raise awareness of Learning Disability and Autism training requirements, with emphasis on:
  - The importance of recognising and recording reasonable adjustments.
  - Accessible communication.
  - Equality and inclusion responsibilities. This remains a key lever for improving both practice and documentation quality.

- **Maintained governance oversight**
  Oversight of this objective continues through established governance routes, including the Learning Disability Steering Group and Safeguarding Committee, ensuring that the priority remains visible during the integration and transformation period.

Key Learning

- **Training awareness remains critical**
  Continued variability in evidenced compliance reinforces the need to further promote and embed Learning Disability and Autism training to support consistent understanding and recording of reasonable adjustments.
- **Practice is ahead of documentation**
  As seen in previous quarters, reasonable adjustments are often being made but not reliably captured within electronic systems, obscuring true performance against the 90% target.

- **Stability phase limits measurable change**
  During this quarter, focus has been on maintaining safe, consistent practice rather than implementing new initiatives. Measurable improvement is therefore unlikely without renewed audit activity and documentation-focused interventions.

Objective 3: Ensure 90% of patients (Adults/Children) with Learning Disability and or autism who are admitted have a Learning Disability specific discharge checklist completed.

Have all measures/monitoring been achieved

- There has been no significant change since Q3 in relation to this objective, and the 90% compliance target has not yet been achieved.
- Discharge planning for patients with a learning disability and/or autism continues to be largely person-centred and MDT-led in practice, with evidence of family involvement, use of hospital passports and reasonable adjustments being considered as part of discharge decision-making. However, there remains no consistent Trust-wide completion or recording of a Learning Disability-specific discharge checklist, limiting assurance against the objective.
- During Q4, no additional audits or new discharge tools have been introduced. Activity has focused on maintaining existing discharge processes during the wider organisational integration period, rather than implementing new documentation requirements or performance measures.

Improvement outcomes

- Although no new measurable improvement outcomes have been identified this quarter, the following position has been maintained:

- **Stable discharge practice for patients with LD/Autism**
  MDT discussions, carer involvement and use of hospital passports continue to support safe and individualised discharge planning across inpatient services.

- **Reasonable adjustments continue to inform discharge decisions**
  Flexible discharge arrangements, communication adjustments and coordination with carers and community services are routinely considered, although not consistently captured within a formal LD-specific checklist.

- **Governance oversight remains in place**
  Assurance continues through existing structures including ward MDTs, daily board

rounds in some areas, Learning Disability Steering Group oversight and Safeguarding Committee reporting.

Key Learning

- **Documentation remains the principal gap**
  As with previous quarters, discharge planning activity is often evident but inadequately recorded, limiting the Trust's ability to demonstrate compliance against the 90% target.

- **Absence of a standardised discharge checklist limits assurance**
  Without an embedded, Trust-approved Learning Disability discharge checklist, compliance remains reliant on variable local documentation practices.

- **Competing priorities during integration restrict progress**
  During this quarter, focus has been placed on maintaining safe discharge practices rather than introducing new tools or audits, resulting in limited measurable movement.

Has this Priority been achieved	Actions being taken
Action behind schedule with mitigation	Although this priority is not currently achieving, full plans are in place (detailed within the above report) to support in the improvement of this work.

QP6: Implementation of Accessible Information Standard relating to communication and reasonable adjustments to improve Patient Experience.

Lead: Emma Hackett, Associate Chief of Nursing for Corporate Services / Susan Dean, Deputy Head of Patient Experience & Inclusion.

What success will look like

Objective 1: Relaunch and embed 5 key steps to ensure accessibility:

1. Ask
2. Record
3. Alert/Flag
4. Share
5. Act

Q4 progress/summary

Objective 1: Relaunch and embed 5 key steps to ensure accessibility:

1. Ask
2. Record
3. Alert/Flag
4. Share
5. Act

Have all measures/monitoring been achieved

- Task and Finish Group has been initiated to include key colleagues in the organisation:
  - Patient Experience and Inclusion Warrington and Halton (WHH).
  - Director of Population Health & Inequalities (WHH).
  - Communication and Engagement Team (WHH).

- Equality and inclusion Bridgewater (BW).
- Digital Services (WHH).

- Key milestones to achieve as per attached action plan include:
  - A new North Cheshire and Mersey (NCM) Accessible Information Standards policy has been developed and ratified and came into effect on 1 April 2026.
  - A gap analysis is underway to review the Trust's current position using the national self-assessment framework.
  - Engagement with digital teams around ensuring there is a robust system in place for placing an alert on the Electronic Patient Record re: communication needs.
  - Communications plan for NCM to include staff training and educational materials being developed.

Key Learning

- Accessible Information standards have been updated to include a 6th stage. As below:
  - Identify
  - Record
  - Flag
  - Share
  - Meet
  - Review
- Opportunity to collaborate with Community & Dental Colleagues.
- Identified key subject headers to include in the policy/programme of work to include:
  - Branding
  - How do we record communication preferences
  - Health literacy
  - Environment and signage
- Aligning with other workstreams to ensure consistency of the accessible information standards (AIS) approach for example:
  - Wayfinding and First Impressions – directional and location signage
  - Patient Engagement Portal - patient letters

Has this priority been achieved	**Actions**
Action on schedule or ongoing	The NCM Accessible Information Standards Policy has been launched. Work is now underway to develop an improvement plan.

Clinical Effectiveness

Clinical Effectiveness: Ensuring practice is based on evidence so that we do 'the right things the right way to achieve the right outcomes' for our patients.
QP7: Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIRFT. recommendations to support timelier and more effective patient care. Leads: Beth Jacobs, Head of Improvement / Claire Leather, Head of Finance GIRFT (Getting it Right First Time).
What success will look like
Objective 1: Urgent and Emergency Care (UEC) Internal and System Improvement Programme

Objective 2: Theatre Improvement Programme
Objective 3: Outpatient Improvement Programme

Q4 progress/ summary

Objective 1: Urgent and Emergency Care (UEC) Internal and System Improvement Programme

Have all measures/monitoring been achieved

Benefit Description	Metric Description	Baseline		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Capped Theatre Utilisation (Internal Dashboard)	Maximise theatre sessions to ensure all specialities are delivering 80% or greater than	March 24/25: 76%)	Target Equal to or greater than	76.20%	76.40%	76.60%	77.00%	77.40%	77.80%	78.20%	78.60%	79.00%	79.40%	79.80%	80.00%
			Actual	78.9%	76.10 %	77.4%	76.9%	78.9%	81.50%	79.3%	80.4%	79.3%	77.5%	79.0%	74.5%
50 Cancellations or less than On the day cancellations (Internal Dashboard)	Will improve theatre utilisation and improve elective recovery position	March 24/25: 71	Target	50	50	50	50	50	50	50	50	50	50	50	50
			Actual	48	54	68	93	79	75	81	74	89	69	82	103
On average all theatre sessions will start on time or no later than 16 minutes late	Will improve Utilisation, and reduce on the day cancellations by reducing overruns	March Last week reporting 36 minutes	Target					19	19	19	18	18	16	16	16
			Actual	21	25	23	25	23	21	20	21	23	24	19	23
Average number of cases per session (Model Hospital Data)	Maximising cases per session with increased utilisation and reduce wait times	March 24/25: 2.3 average cases per session	Target	2.59	2.59	2.59	2.60	2.60	2.61	2.61	2.62	2.62	2.63	2.63	2.64
			Actual	2.5	2.5	2.6	2.0	2.2	2.2	2.4	1.9	2.2	2.5	2.6	2.4
Deliver 75 % of Job Planned Sessions (Manual data pull)	To ensure theatre capacity is maximised to deliver job planned sessions	March 24/25: 57.15%	Target	58.50%	59.75 %	61%	62.25%	63.50%	65%	66.75%	68.33%	70%	71.67%	73.33%	75%
			Actual	60.95%	63.2%	65.93%	59.61%	55.33%	59.35%	63.32%	66.31%	76%	75%	77%	81%
Deliver 80% of Core Funded Theatre Sessions (Manual data pull)	To ensure all Job planned sessions are delivered	March 24/25: 69.17%	Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
			Actual	72.93%	77.2%	87.38%	77.21%	72.48%	80.45%	81.40%	78.82%	68.1%	77%	74%	76.8%
Improve Day Case Rates (Model Hospital data update every Quarter)	To improve our delivery of day cases across identified specialties	March 24/25 85%	Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
			Actual	87.6%			87.7%			86.4%			Q4- TBC		

Improvement outcomes

Preoperative Assessment

- Digital pre-operative questionnaire: A draft version has been developed and configured within the DrDoctor test environment.
- System process review: Engagement has taken place with colleagues at Wigan, Wrightington and Leigh Hospitals to review and gain a clear understanding of the end-to-end process for the sending, receipt and clinical triage of pre-operative questionnaires via DrDoctor.

Federated Data Platform (FDP)- List Planning

- Calculated Adjusted Duration (CAD) procedures data amendments to include multiple procedures in a test environment-now live.
- Benefits realisation paper circulated to The Planned Care Team.

Graphnet

- Data collected on patients planned for Preop appointments, week commencing 16 March 26.

High Volume, Low Complexity (HVLC) Cataracts

- One Stop Clinic feedback is being collated and reviewed.
- Schedule HVLC list for May 2026.
- On going training for nursing staff to administer local drops.

Day Case Arthroplasty

- Theatre lists scheduled with Mr Ali on 22 and 29 April 2026, aiming for same day discharge/discharge within 24 hours. (25 March 2026 and 8 April 2026 pilot lists were cancelled due to long waiters and ambulatory trauma).
- Plan in place for all Captain Sir Tom Moore (CSTM) Ward Nurses to complete physiotherapy mobilisation training by May 26.
- Ongoing audit identifying reasons why length of stay beyond 2 days, discussing solutions and implementing changes.
- Ongoing development of posters, patient leaflets, and digital screens at CSTM promoting same day discharge for hip and knee arthroplasty.
- Patient information leaflet to be sent with all patient letters.

4 Joint Workstream

- Paused due to Trauma and 65-week delivery.
- Requested support from Getting It Right First Time (GIRFT).

Key Learning

Preoperative Assessment

- Confirm with stakeholders to begin with a manual sending and uploading process for completed questionnaires, prior to system integration by The Digital Team.
- Confirm Waiting List teams processes across The Clinical Business Units (CBUs).

FDP Reporting

- Shadow The Countess of Chester scheduling and list planning meetings using FDP, share feedback and lessons learned to further embed FDP with teams (April).
- Agree FDP next steps to support 6-4-2 and reporting.

Graphnet

- Explore how Graphnet intelligence can support managing waiting lists and preop capacity.

HVLC Cataracts

- Develop pre completed cataract consent form to minimise completion time.

Day Case Arthroplasty

- Start discussions and develop plans for recovery staff to support CSTM forward wait for first patient on the list.
- Audit of sip till send to be completed on pilot lists in April.
- PDSA (plan do study act) of April lists completed.
- GP Lunch and Learn, date to be confirmed.

4 Joints Workstream

- Next date to be confirmed due to managing Trauma pressure and long waiters.
- Further discussions GIRFT of how to implement 4 joints as business as usual.

Objective 2: Theatre Improvement Programme

Have all measures/monitoring been achieved

		2025/26 Phasing (Bed days Saved)												
NEL LoS Opportunity		**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**25/26 Total**
Increase % of discharges before 12pm	Plan	1	2	3	3	5	7	9	10	12	14	16	17	**100**
	Actual	1	1	1	1	0	1	2	1	1	2	0	0	**12**
Hot clinics - 8 slots per week	Plan	0	0	9	9	17	17	26	26	35	35	35	35	**243**
	Actual	0	0	14	14	14	14	14	14	14	35	35	35	**203**
Criteria led discharge - increase % weekend discharge	Plan	3	6	8	11	17	22	28	34	39	45	50	56	**319**
	Actual	-4	53	19	-31	89	0	-43	54	-65	19	-36	-15	**41**
Cardiology LoS reduction	Plan	1	2	2	3	5	6	8	10	11	13	14	16	**90**
	Actual	-92	-50	143	83	-152	54	9	-127	-2	93	48	32	**40**
General Medicine LoS reduction	Plan	7	14	21	27	41	55	69	82	96	110	123	137	**781**
	Actual	469	14	-1601	130	671	-130	-498	29	512	-274	-1096	-1775	**-3549**
OPPSU Model - Increase 1-3 Day LoS in >65	Plan	0	0	4	8	11	17	23	30	42	53	65	76	**328**
	Actual	0	0	0	32	33	33	36	37	63	62	58	62	**416**
Virtual Ward - maximise capacity	Plan	91	91	91	91	91	91	91	91	91	91	91	91	**1095**
	Actual	-304	-325	-405	-548	-517	-700	-509	-408	-384	-522	-422	-904	**-5947**
Total Los Opportunity	**Plan**	**103**	**114**	**138**	**153**	**188**	**216**	**253**	**283**	**326**	**360**	**394**	**428**	**2956**
	Actual	70	-307	-1830	-319	138	-727	-989	-399	140	-584	-1414	-2564	**-8784**
	Value £	**29,624**	**-129,404**	**-772,081**	**-134,763**	**58,242**	**-306,655**	**-417,272**	**-168,449**	**59,225**	**-246,570**	**-596,654**	**-1,082,175**	**-3,706,932**

Improvement outcomes

- Surgical Same Day Emergency Care (SDEC) went live 26 February 2026. So far, an average of 22 patients per day have gone through the unit. A large increase in assessment area Type 5 activity was recorded in March 2026 following go live of Surgical SDEC, highest number of attendances since Type 5 recording began.
- There has been an improvement in both 4-hour (3%) and 12-hour (1.3%) performance compared to the previous month as well as improvement from previous year March 2025 performance for 4 hour (2.5%).
- There has been significant improvement in Paediatrics performance for March- 78% compared to average of 71.2% in the previous 3 months.
- This month there has been a reset of the reporting structure and improvement schemes for 2026/27. This has included the re-development of project plans, included aim statements, milestones, terms of reference and identification of workstream and programme leads.
- The three key priorities are:
  1. Reducing length of stay by 0.5 day.
  2. Achieving and maintaining 4-hour standard 82%.
  3. Improving clinical pathways for patients with chronic conditions.

- Each has a programme of working groups focussing on specific aspects of the priority (e.g. Board Round Improvement, Emergency Department Triage or Rheumatology pathway improvement), with oversight by The Clinical Business Unit Managers in the first instance through three ‘Oversight Groups’. These Groups will report to the Unplanned Care Improvement Group and ultimately to Delivery Unit Productivity.

Key Learning

- Confirm future plans for Surgical SDEC.
- Launch of Clinical Operational Standards aligning to refresh of the Integrated Performance System (IPS) with focus on productivity.
- Clinical Capacity Call Launch.
- Corridor Care Summit to be held in May 2026.
- Finalise Emergency Care Improvement Support Team (ECIST) staffing model to determine next steps to support with gaps.

- Continue to work with The Urgent and Emergency Care (UEC) GIRFT to progress and embed 'in flight' schemes (Rapid Assessment and Treatment, Decision to Admit Huddles, Board Round improvement).
- Realise integration opportunities through closer working with Urgent Community Response (UCR) and Widnes Urgent Treatment Centre (UTC), and through pathway driven opportunities.
- Continue to work with system colleagues through UEC System Improvement Structure to reduce admissions and No Criteria to Reside (NCTR).
- Exploration of digital streaming tool at Front Door.
- Completion of Improvement project plans, to include specific, measurable, achievable, relevant, time-bound (SMART) aim statements and establishment of all working groups.

Objective 3: Outpatient Improvement Programme

Have all measures/monitoring been achieved

Benefit Description	Metric Description		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Clinic Utilisation	Maximised booking of all clinic slots to ensure full utilisation of available slots	Target	86%	86.5%	87%	87.5%	88%	89%	90%	91%	92%	93%	94%	95%
	Exc overbooking	Actual	86.64%	87.41%	87.09%	86.20%	86.96%	85.70%	85.52%	85.86%	84.31%	84.69%	84.36%	85.12%
	Inc overbooking		94.98%	95.23%	94.07%	93.60%	94.67%	92.28%	92.95%	93.08%	91.69%	91.58%	91.26%	91.25%
DNA	Reduction in the number of 'Did Not Attends' of patients to both new and follow up outpatient appointments.	Target	8.3%	8.2%	8.10%	8.00%	7.8%	7.47%	7.14%	6.81%	6.49%	6.16%	5.83%	5.5%
		Actual	8.25%	8.87%	8.61%	8.40%	8.42%	8.72%	8.36%	8.69%	9.45%	8.68%	7.74%	7.51%
Short notice cancellations	Reduction in the number of less than 6-week clinic cancellations taking place by the Hospital.	Target	7.6%	7.5%	7.4%	7.3%	7.14%	6.98%	6.81%	6.65%	6.49%	6.33%	6.16%	6%
		Actual	7.46%	6.46%	7.29%	7.89%	7.46%	7.41%	7.16%	7.99%	7.77%	6.78%	7.20%	7.39%
PIFU	Additions to PIFU access plan as % of Outpatient Attendances	Target	5% 18.2%	5% 18.2%	5% 18.4%	5% 18.8%	5% 19%	5% 19.43%	5% 19.86%	5% 20.2%	5% 20.71%	5% 21.14%	5% 21.57%	5.00% 22.00%
	Discharge rate at OPA	Actual	4.21% 17.88%	4.04% 18.03%	4.04% 18.50%	4.16% 18.29%	3.99% 19.07%	3.91% 19.04%	4.20% 18.45%	4.30% 18.28%	4.13% 18.71%	4.53% 17.89%	4.45% 17.94%	4.97% 17.31%
New to Follow up Ratio	The ratio of new appointments to follow up appointments per patient.	Target	2.87	2.84	2.84	2.67	2.66	2.64	2.63	2.61	2.60	2.58	2.57	2.55
		Actual	2.73	2.52	2.48	2.64	2.59	2.56	2.69	2.70	2.51	2.48	2.39	2.34
Advice and Guidance	Diversion Rate	Target	32%	32%	32%	32%	32%	32%	34%	36%	38%	40%	42%	>44%
		Actual	33%	38%	39%	37%	36%	38%	42%	37%	36%	23%	TBC	TBC
	Turnaround time <2 days	Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
		Actual	63%	60%	60%	73%	64%	62%	62%	62%	62%	65%	74%	TBC

Improvement outcomes

- Progression with clinic template work.
- Pre-op advanced access plans increasing, positively impacting the new: follow up ratio but experiencing delays related to current workflows, Patient Administration System (PAS) functionality and booked clinics.
- Availability of slot level report; increasing clinic utilisation by on average +1% monthly.
- Did Not Attend (DNA) AI tool within Patient Engagement Portal now live for 11 specialties with highest DNA rates. All patients receiving additional text reminder from 23 February 2026. Impact is being monitored.
- Final stages of Outpatient dashboard development – go live within March.
- New Patient Intimated Follow Up (PIFU) policy approved.
- Agreement to proceed with test of change for 'State the cost' messaging. Patient messaging updated from 16 February 2026. Impact is being monitored.
- Approval of funding for dedicated support to continue the Clinic Template project until February 2027.

- Mandatory recording of rationale for relisting any DNA live from 16 March 2026.
- Recruited first Courtesy Caller volunteer to contact patients identified as high and medium risk of future DNA.

Key Learning

- Continuation with clinic template work.
- Continue to work on aligning digital and operational priorities, including Attend Anywhere project.
- Progression with engagement and feedback for Trust wide policies/SOP for Telephone clinics and 'Outpatient whilst an Inpatient' to support reduction in DNA rates.
- Access impact and implications of draft Patient Not Present guidance.
- Deep dive into current recording of Appointment type (New/FUP) for nonelective admissions.
- Continue recruitment for additional Courtesy Caller volunteers.
- Monitor impact of targeted actions to reduce DNA rates in DNA AI pilot.

Has this Priority been achieved	**Actions being taken**
Action behind schedule with mitigation	Although the Trust is currently partially achieving this priority, progress is being made through several pieces of work to make further improvements with an aim to fully achieve this priority.

QP8: Reduce Cancer Waiting Times.
Leads: Dr Mithun Murthy, Associate Medical Director for Clinical Effectiveness / Karen Mason, Cancer Nurse Transformation Manager

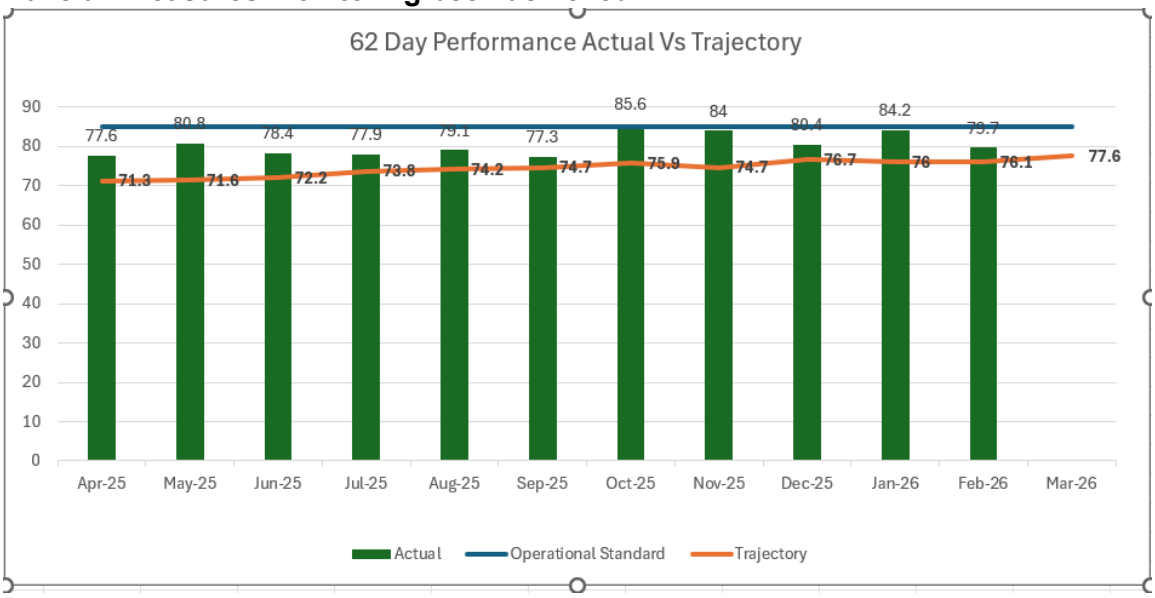
What success will look like

Objective 1: Improve and sustain performance against the headline 62-day cancer standard to 75% by March 2026.
Objective 2: Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026.of discharges before 12 noon

Q4 progress/summary

Objective 1: Improve and sustain performance against the headline 62-day cancer standard to 75% by March 2026.

Have all measures/monitoring been achieved



Improvement outcomes

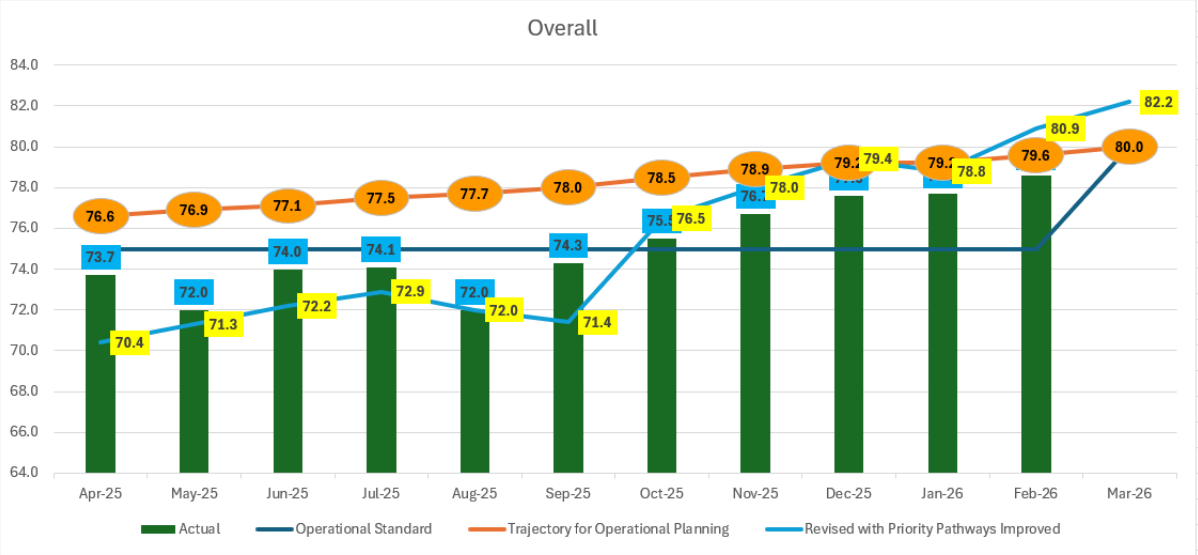
- The standard is currently performing over the agreed trajectory to reach 75% by March 2026 and the Trust has been referenced as one of the most improved nationally in recent newspaper reports and the Health Service Journal (HSJ).
- The operational standard remains at 85% and the ultimate aim of the organisation is to consistently achieve this. This was achieved for the first time in a number of years in October 2025.
- The commitment for 2026/27 will be to achieve 80% by March 2027.
- The Trust is also now working to integrate skin cancer performance previously reported by Community & Dental.

Key Learning

- More focus on weekly Patient Tracking Lists (PTL) meetings with Clinical Business Units discussing patient level detail.
- Implementation of updated escalation policy.
- Upgrading of more patients onto a 62-day pathway with a revamped supporting policy widely circulated.
- Working with tertiary centres to ensure pathways between organisations are seamless

Objective 2: Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026.

Have all measures/monitoring been achieved



Improvement outcomes

- 28-day Faster Diagnosis Standard (FDS) remains challenging and is currently performing under trajectory.
- Extensive work has been done in conjunction with the services and the Cancer Alliance to develop action plans against our 3 highest priority pathways in Gynaecology, Lower Gastrointestinal and Urology with the aim of achieving an aggregate performance of 80% by March 2026. This has been achieved.

Key Learning

- Robust action plans are in place, and improvement is being seen throughout Q4.
- It is essential to constantly monitor and escalate areas that are preventing improvement for example Radiology and Endoscopy.
- As a result of escalation funding was secured for MRI which has significantly improved the Urology pathway performance.

Has this Priority been achieved	Actions being taken
Action behind schedule with mitigation	The Trust is fully achieving objective 1 of this priority. Objective 2 remains challenging. Robust actions are in place, and the improvement plan is monitored by The Cancer Improvement Forum monthly.

QP9: Improve Theatre Safety Culture using whole quality system approach and robust governance process.

Leads: Dr Mithun Murthy, Associate Medical Director for Clinical Effectiveness/Dr Anna Vondy, Clinical Director of Planned Care/Sonia Griffin, Associate Chief Nurse of Planned Care.

What success will look like

Objective 1: Quality Surveillance and Assurance. Standardised implementation of NATSSIPs, observational audit tool as well as documentation audit with greater than 90% compliance, across all theatre areas and appropriate escalation to Patient Safety Steering Group (PSSG) and Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC).
Objective 2: Training and Awareness. Create and embed an E-learning package on 8 steps to safer surgery in line with the NATSSIPs 2 across all relevant staff groups.
Objective 3: Culture. To build and embed a culture of safety and continuous improvement in theatres.

Q4 progress/summary

Objective 1: Quality Surveillance and Assurance. Standardised implementation of NATSSIPs, observational audit tool as well as documentation audit with greater than 90% compliance, across all theatre areas and appropriate escalation to Procedural Safety Steering Group (PSSG) and Patient Safety, Clinical Effectiveness Sub-Committee (PSCESC).

Have all measures/monitoring been achieved

- Standardised theatre observational audit tool fully live embedded across all theatre areas. Following recent near miss Never Event (NE), frequency of observational audits increased from 1 audit per site per day to 2 audits per site per day.
- Standardised process of escalation of Procedural Safety Steering Group (PSSG) to Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) in place via a monthly high level briefing paper (HLBP).
- The Theatre Governance Group also reports up to PSSG via a chair's report. Terms of reference for this group are being reviewed as challenges of quoracy have been noted. (meeting has taken place 5 out of the last 6 months but not always quorate).
- 1 further NE in Q4, which was deemed a near miss. Relating to prosthesis sizing, it was appropriately investigated with After Action Reviews (AAR) and immediate safety steps including amending the Prosthesis pause standard operating procedure (SOP).
- Further presentation of The Mersey Internal Audit Agency (MIAA) action plan follow-up at The Quality Assurance Committee (QAC) April 2026.
- Theatre Matron daily checklist to be reviewed by the Theatre Manager and Digestive Diseases Lead Nurse and to be re-invigorated to ensure all audit and debrief check taking place across all sites.

Improvement outcomes

- Sustained compliance of greater than 90% has been achieved across all theatre areas, as evidenced through ongoing observational and documentation audits.
- The majority of actions within the MIAA action plan have been completed, with the remainder on track for delivery.
- Following the resignation of the Deputy Associate Medical Director for Clinical Effectiveness (Procedural Safety), Executive Control Framework (ECF) approval for reappointment has been secured and is awaiting final executive sign-off prior to readvertisement.
- The Prosthesis Pause Standard Operating Procedure (SOP) has been reviewed and strengthened to improve robustness and clarity.

Key Learning

- True collaborative working of theatre senior leadership, Planned Care Triumvirate and the Associate Medical Director procedural safety via PSSG and transparent and robust escalation via PSSG to PSCESC.
- Safe surgery audit tool developed as Lorenzo form with the aim of automated data collection via power BI. However, robustness of data quality and formatting is being reviewed.
- Pitfalls noted within the prosthesis pause procedure as part of near miss investigation, led to key changes to SOP.

Objective 2: Training and Awareness. Create and embed an E-learning package on 8 steps to safer surgery in line with the NATSSIPs 2 across all relevant staff groups.

Have all measures/monitoring been achieved

8 steps to safer surgery e-learning:

- E-learning package is now ready and available for all staff (since July 2025) on ESR but not yet made part of mandatory training for all relevant staff.
- These discussions had previously stalled due to workforce gaps in key personnel. However, further meetings have taken place between The Digestive Diseases Clinical Business Unit Manager and Learning and Development to progress this action at pace. This will be followed up once new Deputy Associate Medical Director for Clinical Effectiveness in post as well.

Improvement outcomes

- The e learning? has continued to be popularised via all the Planned Care Clinical Directors and Associate Medical Director, as well as theatre leadership.
- More than 100 staff members have completed training; however, we are unable to produce accurate compliance figures via ESR or staff PDRs as training has not yet been made mandatory. This is awaiting sign off by The Learning & Development Team.

Key Learning

- Compliance with e-learning package to be triangulated with governance data to analyse effectiveness of the training – to be regularly discussed at PSSG.

Objective 3: Culture. To build and embed a culture of safety and continuous improvement in theatres.

Have all measures/monitoring been achieved

- The Theatre Safety Culture Workstream is managed via The Theatre Culture Improvement Group led by The Planned Care Triumvirate since January 2025. The meeting frequency is bi-weekly and involves key personnel from The People's Directorate. The Planned Care Triumvirate have reviewed the terms of reference and process of escalation of actions from the group. However, meetings have not taken place since the end of Q3 and all Q4 due to lack of quoracy.

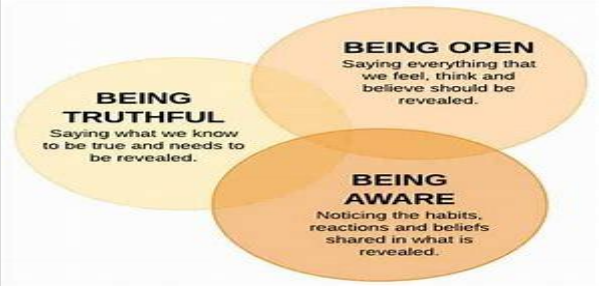
- Safe surgery (medical) champion has also not been able to be appointed due to budgetary constraints.

Improvement outcomes

- Theatres and planned care have requested an internal independent “pressure test” by The Learning & Development Team as a ‘mock MIAA’ inspection. This was to take place in January/February 2026 but has been pushed back due other competing constraints such as organisational acquisition. MIAA invitation for re-audit has also been pushed back to Q2/3 2026/27. Both these actions have now been picked up by Digestive Diseases Clinical Business Unit Team.

Has this Priority been achieved	Actions being taken
Action on schedule or ongoing	This priority is currently on track, and work streams are progressing on track with appropriate escalations established.

Further to the agreed Quality Priorities 2025/26 Warrington and Halton Teaching Hospitals NHS Foundation Trust has also achieved a number of quality measures that evidence improvement across all three domains of quality. These include:



Statutory Duty of Candour Requirements

The Trust continues to consistently achieve 100% compliance in the notification of Duty of Candour both verbal and written (within 10 working days) following the occurrence of a notifiable patient safety incident.

Warrington and Halton Diagnostics Centre at Halton Hospital

Increasing our capacity in facilities like this is key to us delivering timelier diagnostic testing for patients in locations that are modern, accessible, and away from acute hospital settings.
The new MRI scanner uses artificial intelligence (AI) to reduce scan times – some by up to 70% - and the new CT scanner delivers up to 81% less radiation than older models, making it quicker, safer and more comfortable for our patients.

Improving our Bowel Cancer Waiting Times

We have introduced a Colorectal Nursing Triage Team to streamline pathways, enabling treatment to begin sooner for those who need it and providing earlier reassurance for those who do not. The team is proud of this work and is committed to making a meaningful difference to the experience and outcomes of our patients.

Opening of Ward K25 – Older Persons Short Stay Unit

The aim is to support the safe discharge of frail patients within 72 hours, reducing the risks associated with prolonged hospital stays, including infection, delirium and deconditioning. This approach will improve patient experience, optimise bed utilisation and reduce overall length of stay, building on the established skills and expertise of the Frailty Team

WHH HR Team highly commended at The National People Management Awards

The team was recognised in the *Health Education and Improvement Wales Award* for *Developing the Profession and People Professionals* for its work in establishing a structured career development pathway within the Human Resources Department.

People's Choice Award Winner

Members of the public were once again invited to nominate staff and volunteers at Warrington and Halton Hospitals for recognition through the Trust's Annual Thank You Awards. A Specialist Nurse from the Colorectal Team was recognised for her inspirational commitment to supporting patients throughout their cancer journey

2.2 Our Strategic Aims of Quality 2026/27.

In line with the Trust's future vision, sustained focus has been maintained on the delivery of our Strategic Aim of Quality. This is supported through the achievement of three Strategic Objectives, aligned to the recognised quality domains of Patient Safety, Clinical Effectiveness and Patient Experience

- **Priority 1 - Patient Safety:** We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.

- **Priority 2 - Clinical Effectiveness:** We will ensure practice is based on evidence so that we do 'the right things in the right way to achieve the right outcomes' for our patients.

- **Priority 3 - Patient Experience:** We will place the quality of patient experience at the heart of all we do, where "seeing the person in the patient" is the norm.

The Trust is committed to embracing improvement across a wide range of quality issues to achieve excellence in all areas of care using the following measures of success and all are supported by a separate group of indicators which are detailed further on.

- ✓ We will ensure every patient has the opportunity to feedback about their experience and we promise to use this to improve care and services.
- ✓ We will always put our patients first in everything we do, and we promise to communicate based on what matters most to you and in line with our values.
- ✓ We will ensure that we minimise harm for patients.
- ✓ Our patients should always experience care that is based on their specific needs, and we promise to work in partnership with you and your carers to achieve best possible outcomes.
- ✓ Every patient should experience care and treatment in the right environment, and we promise to continuously improve what you can see, do, hear and feel during your stay.
- ✓ Our processes should be designed to support our patients, and we promise to develop these so that everything is simple, done in a timely manner and easy to understand.
- ✓ We will be the best place to work and have safe systems of work in place.
- ✓ We will ensure partnership working and needs based care.

With the above measures of success in mind, the infographics below demonstrate our focused commitment to continually improve our services across the three domains of quality in 2026/27.

2.3 Looking Ahead – Our Quality Priorities 2026/27.

Warrington and Halton Teaching Hospitals, NHS Foundation Trust has utilised internal intelligence using our Learning from incidents, complaints, claims and risk has also been utilised to inform the proposed quality priorities 2026/27. The agreed Quality Priorities are outlined below. Progress will be monitored through quarterly reports submitted to the Patient Safety and Clinical Effectiveness Sub Committee and to the Trusts Quality Safety Assurance Committee, which in turn provides assurance to the Trust Board of Directors.

2026/27 Quality Priorities

NHS North Cheshire and Mersey NHS Foundation Trust

The improvement aims	Description of Quality Priorities	The outcome
Improve patient safety	1. Ensure there is appropriate escalation of care when required, with critical information reliably and clearly communicated and understood during handover, and improved communication with patients and families 2. Prevent and reduce harm from Pressure Ulcers and Community Acquired Moisture Associated Skin Damage, Malnutrition, and Sepsis.	Patient safety is enhanced through a learning culture where quality and safety is everyone's top priority
Improve clinical effectiveness	3. Monitor and Improve compliance with non-theatre safety standards (*LocSSIPs-Local Safety Standards for Invasive Procedures*) within relevant scope of acute and community services. 4. Monitor and Improve compliance with theatre safety standards (*NatSSIPs-National safety standards for invasive procedures*)	Practice is based on evidence so that we do the right things the right way to achieve the right outcomes for our patients
Improve patient experience	5. Strengthen staff wellbeing and emotional support following patient safety incidents.	The quality of the patient experience is at the heart of all we do and 'seeing the person in the patient' is the norm

2.4 Statements of Assurance from the Board of Directors

The information in this section is mandatory text that all NHS Foundation Trusts must include in their Quality Account. We have added an explanation of the key terms and explanations, where applicable.

2.5 Information on the Review of services.

During 2025/26, the Warrington and Halton Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 6 relevant Health Services.

The Warrington and Halton Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 6 of these relevant Health Services (contracted services).

The income generated by the Health Services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant Health Services by the Warrington and Halton Teaching Hospitals NHS Foundation Trust for 2025/26.

2.6 Participation in National Clinical Audits and National Confidential Enquiries 2023-24.

What is a clinical audit: Clinical audit forms an integral part of the Clinical Governance Framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care. Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic measurement against explicit criteria and the implementation of any necessary change(s): New Principles of Best Practice in Clinical Audit, Healthcare Quality Improvement Partnership, 2020.

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes healthcare professionals participating in regular clinical

audit. Clinical audit is the governance vehicle in relation to determining assurance within clinical practice and is integral to the core business of the Trust.

The Clinical Audit Department is committed to raising the profile of clinical audit within the Trust recognising the importance of the annual forward audit plan and its contribution to improving patient outcomes and experience. The Trust-wide Forward Audit Plan 2025-26 was implemented at the start of the financial year following approval by the Patient Safety and Clinical Effectiveness Committee and by the Quality Assurance Committee.

On an annual basis, NHS England publishes a list of national clinical audits and clinical outcome review Programmes that it advises Trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing alongside new items. NHS England Quality Accounts List 2025-26 has been confirmed and available from HQIP website via the following link https://www.hqip.org.uk/wp-content/uploads/2025/08/20250811_NHSE-QA-List-2025-26_FINALv3.pdf

The Trust is also committed to undertaking local clinical audits many of which focus upon some of the greatest challenges experienced by the population that we serve. The information below provides an overview of all the national clinical audits, confidential enquiries and local clinical audits undertaken during 2025-26.

2.6.1 Participation in Quality Account Clinical Audits 2023-24.

During 2025-26, 63 National Clinical Audits and 10 national confidential enquiries covered relevant health services that Warrington and Halton Teaching Hospitals NHS Foundation Trust provides.

During that period, Warrington and Halton Teaching Hospitals NHS Foundation Trust participated in:

- 95% of the national clinical audits.
- 100% of the national confidential enquiries of the national clinical audits.
- National confidential enquiries which it was eligible to participate in as detailed in the table below.

The table below shows:

- The national clinical audits and national confidential enquiries that Warrington and Halton Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2025-25.
- The national clinical audits and national confidential enquiries that Warrington and Halton Teaching Hospitals NHS Foundation Trust participated in during 2025-26.
- The national clinical audits and national confidential enquires that Warrington and Halton Teaching Hospitals NHS Foundation Trust participated in, for which data collection was completed during 2025-26. These are listed below alongside the number of cases submitted to each audit or enquiry.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
1	**BAUS Data & Audit Programme**			
	a) British audit of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	Yes	No	
	b) Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Yes	No	
2	**Breast and Cosmetic Implant Registry**	Yes	Yes	9 cases submitted, ongoing data submission.
3	**British Spine Registry**	N/A		
4	**Case Mix Programme (CMP)**	Yes	Yes	Intensive Care Unit April-March 2023-24 677 cases Ongoing data submission.
5	**Child Health Clinical Outcome Review Programme**	Yes	Yes	See table below with National Confidence Enquiry into Patient Outcome and Death Information.
6	**Cleft Registry and Audit Network (CRANE) Database**	N/A		
7	**Emergency Medicine QIPs**			
	A) Adolescent Mental Health	Yes	Yes	Only opened in 2026
	b) Care of Older People	Yes	Yes	247 cases submitted, ongoing data submission.
	c) Mental Health (Self-Harm)	Yes	Yes	256 cases submitted, ongoing data submission.
	d) Time Critical Medications	Yes	Yes	62 doses form data 47 cases submitted, ongoing data submission.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
8	**Epilepsy 12 - National Clinical Audit of Seizures and Epilepsy for Children and Young People**	Yes	Yes	21 cases submitted, for cohort 6 (January to December 2024), ongoing data submission.
9	**Falls and Fragility Fracture Audit Programme:**			
	a) Fracture Liaison Service Database (FLS-DB)	N/A		
	b) National Audit of Inpatient Falls (NAIF)	Yes	Yes	8 cases 1 January 2024 – 31 December 2024 ongoing data submission.
	c) National Hip Fracture Database (NHFD)	Yes	Yes	386 cases submitted, ongoing data submission.
10	**Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)**	Yes	Yes	Not a clinical audit section.
11	**Maternal, Newborn and Infant Clinical Outcome Review Programme**	Yes	Yes	Multiple studies: WHH Neonatal mortality rate for 2023 was 1.2 per 1000 live births. WHH stillbirth rate for 2023 was 2.02 per 1000 births
12	**Medical and Surgical Clinical Outcome Review Programme**	Yes	Yes	See table below with National Confidence Enquiry into Patient Outcome and Death Information.
13	**Mental Health Clinical Outcome Review Programme**	N/A		
14	**National Adult Diabetes Audit (NDA):**			
	a) National Diabetes Core Audit.	Yes	Yes	1157 cases submitted, ongoing data submission.
	b) Diabetes Prevention Programme (DPP) Audit	Yes	Yes	Information is drawn from the National

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				Diabetes Audit. Ongoing data submission.
	c) National Diabetes Footcare Audit (NDFA)	Yes	Yes	126 cases submitted, ongoing data submission.
	d) National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	12 cases submitted, ongoing data submission.
	e) National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	18 cases– however 25 total for the 2025 data collection (01/01/2025 – 31/12/2025) (Deadline date was 26/02/2026).
	f) Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Yes	Any paediatric or adult diabetes services that participate in either the NPDA or NDA are automatically included. No additional data submission is needed.
	g) Gestational Diabetes Audit	Yes	Yes	Data collected directly from Maternity Services dataset (MSDS) – Ongoing data collection
15	**National Audit of Cardiac Rehabilitation**	Yes	Yes	563 cases submitted, ongoing data submission. Emailed the lead
16	**National Audit of Cardiovascular Disease Prevention in Primary Care (CVD Prevent)**	N/A		
17	**National Audit of Care at the End of Life**	Yes	Yes	60 cases – however 80 total from 01/01/2025 – 31/12/2025.
18	**National Audit of Dementia (NAD)**	Yes	Yes	This audit did not run during 2025-26
19	**National Audit of Eating Disorders (NAED)**	N/A		
20	**National Bariatric Surgery Registry**	N/A		

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
	National Cancer Audit Collaborating Centre (NATCAN)			
21	**National Audit of Metastatic Breast Cancer (NAoMe)**	Yes	Yes	These audits are now incorporated within the Cancer Outcomes and Services Data set (COSD) monthly return, data not available at present.
22	**National Audit of Primary Breast Cancer (NAoPri)**	Yes	Yes	As above.
23	**National Bowel Cancer Audit (NBOCA)**	Yes	Yes	As above.
24	**National Kidney Cancer Audit (NKCA)**	Yes	Yes	As above.
25	**National Lung Cancer Audit (NLCA)**	Yes	Yes	As above.
26	**National Non-Hodgkin Lymphoma Audit (NNHLA)**	Yes	Yes	As above.
27	**National Oesophago-Gastric Cancer Audit (NOGCA)**	Yes	Yes	As above.
28	**National Ovarian Cancer Audit (NOCA)**	Yes	Yes	As above.
29	**National Pancreatic Cancer Audit (NPaCA)**	Yes	Yes	As above.
30	**National Prostate Cancer Audit (NPCA)**	Yes	Yes	As above.
31	**National Cardiac Arrest Audit (NCAA)**	Yes	No	N/A
32	**National Cardiac Audit Programme (NCAP):**			
	a) National Adult Cardiac Surgery Audit (NACSA)	N/A		
	b) National Congenital Heart Disease Audit (NCHDA)	N/A		
	c) National Heart Failure Audit (NHFA)	Yes	Yes	339 cases submitted, ongoing data submission.
	d) National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	205 cases submitted, ongoing data submission.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
	e) Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	180 cases submitted, ongoing data submission.
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	N/A		
	g) UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N/A		
	h) Left Atrial Appendage Occlusion (LAAO) Registry	N/A		
	i) Patent Foramen Ovale Closure (PFOC) Registry	N/A		
	j) Transcatheter Mitral and Tricuspid Valve (TMTV) Registry2	N/A		
33	**National Child Mortality Database (NCMD)**	Yes	Yes	All deaths of children from the Warrington and Halton areas are discussed at the CDOP (Child Death Overview Panel) and this feeds into the NCMD.
34	**National Clinical Audit of Psychosis (NCAP)**	N/A		
35	**National Comparative Audit of Blood Transfusion:**			
	2025 Major Haemorrhage Audit	Yes	Yes	24 cases – 100% of sample required.
36	**National Early Inflammatory Arthritis Audit (NEIAA)**	Yes	No	Capacity issues with submitting data to this audit currently under review
37	**National Emergency Laparotomy Audit (NELA)**			
	a) Laparotomy	Yes	Yes	136 cases submitted, (for year 12) ongoing data submission.
	b) No Laparotomy	Yes	Yes	0 cases submitted, ongoing data submission.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
38	**National Joint Registry**	Yes	Yes	Latest published data: April 2023 – March 2024 The Cheshire & Merseyside Treatment Centre (CMTC) 608+ cases. WHH 178+ cases submitted, ongoing data submission.
39	**National Major Trauma Registry**	Yes	Yes	Data submitted under the Merseyside and Cheshire Network
40	**National Maternity and Perinatal Audit (NMPA)**	Yes	Yes	2379 women with one or more registerable births, ongoing data submission.
41	**National Neonatal Audit Programme (NNAP)**	Yes	Yes	234 total neonatal admissions between January 2024 and December 2024, ongoing data submission.
42	**National Obesity Audit (NOA)**	N/A		
43	**National Ophthalmology Database (NOD)**			
	a) Age-related Macular Degeneration Audit	Yes	Yes	237 cases 01 April 2023 – 31 March 2024
	b) Cataract Audit	Yes	Yes	01 April 2024 – 31 March 2025 this data is being currently processed and analysed by the national body. Figures will be available in July 2026.
44	**National Paediatric Diabetes Audit (NPDA)**	Yes	Yes	166 cases. Ongoing data submissions.
45	**Perinatal Mortality Review Tool (PMRT)**	Yes	Yes	All live birth, up to 28 days of age. More than 22 weeks gestation and any still births are

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				discussed and feed into the National PMRT database.
46	**National Pulmonary Hypertension Audit**	N/A		
47	**National Respiratory Audit Programme (NRAP)**			
	a) COPD Secondary Care	Yes	Yes	476 cases. Ongoing data submission.
	b) Pulmonary Rehabilitation	Yes	Yes	386 cases. Ongoing data submission.
	c) Adult Asthma Secondary Care	Yes	Yes	123 cases. Ongoing data submission.
	d) Children and Young People's Asthma Secondary Care	Yes	Yes	23 cases. Ongoing data submission. ongoing data submission.
48	**National Vascular Registry (NVR)**	N/A		
49	**Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)**	N/A		
50	**Paediatric Intensive Care Audit Network (PICANet)**	N/A		
51	**Perioperative Quality Improvement Programme**	Yes	Yes	1 case submitted in that time frame; as 20 have been completed but awaiting 6/12-month review to be completed.
52	**Prescribing Observatory for Mental Health (POMH):**			
	a) Improving the quality of valproate prescribing in adult mental health services	N/A		
	b) The use of clozapine	N/A		
	c) Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	N/A		

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
53	**Sentinel Stroke National Audit Programme (SSNAP)**	Yes	Yes	April 2024 to March 2025. 183 cases submitted, ongoing data submission.
54	**Serious Hazards of Transfusion UK National Haemovigilance Scheme**	Yes	Yes	13 reports to SHOT this year. 3x Wrong Blood in Tubes 3x Handling & Storage errors 2x errors relating to Anti-D 1x Right Blood Right Patient 1x Component Labelling error 1x Component Collection error 1x Allergic Reaction 1x Over-Transfused
55	**UK Cystic Fibrosis Registry**			
	a) Cystic fibrosis - Adults	N/A		
	b) Cystic fibrosis - Children	Yes	Yes	22 cases submitted, ongoing data submission
56	**UK Interstitial Lung Disease (ILD) Registry**	N/A		
57	**UK Parkinson's Audit**	Yes		• Occupational therapy, Neuro Outpatients, Halton Hospital - 10 patient cases submitted. • Physiotherapy, Warrington and Halton Hospital - 10 patient cases submitted. • Pharmacy, Warrington and Halton Hospital - 10 patient cases submitted.

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				In each case, 10 was the minimum patient case requirement
58	**UK Renal Registry Chronic Kidney Disease Audit**	Yes	Yes	Data submitted via Royal Liverpool Hospital. Latest figures 2023. Ongoing data collection: Regional figures reported, as we are a satellite centre. Transplant: 845 adult cases submitted. Home haemodialysis: 62 adult cases submitted. In centre haemodialysis: 541 cases submitted. Peritoneal Dialysis: 55 adult cases submitted.
59	**UK Renal Registry National Acute Kidney Injury Audit**	Yes	Yes	Latest data submitted to AKI Laboratory Portal in 2025-2026, AKI stages 1, number of AKI episodes: Q1 (2025) 709 alerts submitted via lab. Q2 (2025) 828 alerts submitted via lab. Q3 (2024) 867 alerts submitted via lab. Q4 (2025) 930 alerts submitted via laboratory (lab).

National Clinical Audits				
HQIP Count	**National clinical audits and clinical outcome review programmes**	**Eligible**	**Participated**	**Number of cases submitted**
				Ongoing data collection.

National Confidential Enquiries				
HQIP ID No.	**National Confidential Enquiries**	**Eligible**	**Participated**	**Number of cases submitted**
1.	Rib Fracture	Yes	Yes In Progress	6 clinician questionnaires have been assigned. All 6 questionnaires have been assigned to the relevant clinicians and are track for completion with the deadline of 10 May 2026.
2.	Stabilisation of the critically ill child	Yes	Yes	4 Clinician questionnaires were originally assigned but NCEPOD removed two of the questionnaires, leaving 2 remaining. Both remaining questionnaires were completed and submitted. **The report is yet to be published. Expected publication date: December 2026**
3.	Pleural Procedures	Yes	Yes In Progress	8 Clinician questionnaires have been assigned. 8 questionnaires have been completed and submitted. **The report is yet to be published. Expected publication date: November 2026**
4.	Acute Limb Ischaemia Study	Yes	Yes	1 Organisational Questionnaire was assigned to the Trust and 1 request for patient records was received. Both the Organisational questionnaire and the patient records were completed and submitted.

National Confidential Enquiries				
HQIP ID No.	**National Confidential Enquiries**	**Eligible**	**Participated**	**Number of cases submitted**
				The report is yet to be published. Expected publication date: November 2025
5.	Hyponatraemia	Yes	Yes	6 Clinician questionnaires were assigned. All 6 questionnaires were completed and submitted. **The report 'A Balanced Solution – A review of the quality of care in the hospital provided to adults with abnormal levels of blood sodium' was finalised and published 9 October 2025.** Following the publication of the study the full report has been shared with the relevant teams for awareness of the local level implementation suggestions that were noted within the report.
6.	Acute Limb Ischaemia Study	Yes	Yes	1 Organisational Questionnaire was assigned to the Trust and 1 request for patient records was received. Both the Organisational questionnaire and the patient records were completed and submitted. **The report 'Risking Life and Limb – A review of the quality of the care provided to adults with acute limb ischaemia' was finalised and published 13 November 2025.** Following the publication of the study the full report has been shared with the relevant teams for awareness of the local level implementation suggestions

National Confidential Enquiries				
HQIP ID No.	**National Confidential Enquiries**	**Eligible**	**Participated**	**Number of cases submitted**
				that were noted within the report.
7.	Emergency (non-elective procedures in children and young people: Transfer	Yes	Yes	2 Clinician questionnaires were assigned. 1 questionnaire has been completed. The remaining questionnaire has been removed from the system as the patient was not treated at Warrington and Halton Hospitals. **The report 'Right Place, Right Time, Right Team – A review of the quality of care provided to children and young people needing emergency surgery' was finalised and published 11 December 2025.** Following the publication of the study the full report has been shared with the relevant teams for awareness of the local level implementation suggestions that were noted within the report.
8.	Emergency (non-elective procedures in children and young people: Anaesthetic	Yes	Yes	7 Clinician questionnaires were assigned. 7 questionnaires have been completed and submitted. **The report 'Right Place, Right Time, Right Team – A review of the quality of care provided to children and young people needing emergency surgery' was finalised and published 11 December 2025.** Following the publication of the study the full report has been

National Confidential Enquiries				
HQIP ID No.	**National Confidential Enquiries**	**Eligible**	**Participated**	**Number of cases submitted**
				shared with the relevant teams for awareness of the local level implementation suggestions that were noted within the report.
9.	Emergency (non-elective procedures in children and young people: Surgical	Yes	Yes	7 Clinician questionnaires were assigned, and 1 Organisational Questionnaire was assigned. All 7 clinician questionnaires and 1 Organisational questionnaire have been completed and submitted. **The report 'Right Place, Right Time, Right Team – A review of the quality of care provided to children and young people needing emergency surgery' was finalised and published 11 December 2025.** Following the publication of the study the full report has been shared with the relevant teams for awareness of the local level implementation suggestions that were noted within the report.
10.	Learning Disability	Yes	Yes	6 Clinician and 1 Organisational questionnaire were assigned. 3 questionnaires and 1 Organisational questionnaire was completed and submitted by the date the study closed. **This report is yet to be published. Expected publication date: Summer 2026**

The reports of 10 national clinical audits were reviewed by the Trust in 2025-26, and Warrington and Halton Teaching Hospitals NHS Foundation Trust will take the following actions to improve the quality of healthcare provided:

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
1	National Ophthalmology Database (NOD) 1 April 2022 - 31 March 2023	Posterior capsular rupture (PCR) is the most common complication during cataract surgery and if this happens there is an increased risk of post-operative complication. • WHH results – 0.8% completed without complication compared to 1.1% nationally. This audit provides assurance that delivery of NHS-funded treatment for cataracts is of good quality overall and within expected limits. Action plan for improvement - not required.
2	Cardiac Rhythm Management (CRM) 1 January 2023 - 31 December 2024 Round 6	Trust metrics are higher than national figures demonstrating that WHH are meeting recommended services and, therefore, in a good place despite the limited resources available. Action plan for improvement - not required.
3	National Audit of Dementia (NAD) 1 August 2023 - 31 January 2024	The Trust audit findings for Round 6 of NAD were positive, with the key metrics all scoring above the national average. Progress has already been made increasing the number of patients being screened for delirium using the 4AT. This is reflected in the audit's findings from round 5 (13%) compared to round 6 (44%) with the National average for round 6 being 38%. However, there is further progress required to ensure that all individuals at risk of delirium are screened effectively using the validated 4AT screening tool. Action plan for improvement – • Continued quality improvement initiatives which relate to increasing the percentage of patients (who are identified at risk of delirium) screened for delirium using the 4AT tool. • Explore how the dementia form on Lorenzo can be utilised monitor compliance of the 'this is me document' and Abbey Pain Tool.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
4	Society for Acute Medicine Benchmarking Audit (SAMBA) 20 June 2024	Discussions took place at the Patient Safety and Clinical Effectiveness Sub Committee (PSCESC) around the metrics but overall, it was felt that a “good” rating for governance should be noted and a “moderate” for delivery. The SAMBA Lead felt that WHH should have improved in the indicators in the 2025 audit due action plans that are in place. Action plan for improvement - • Correlation of SAMBA Data with 7 Day Service Audit in Acute Medicine Clinical Standard 2. • Implementation of Medical Registrar/Internal Medical Trainee teaching sessions to improve prioritisation and efficiency when on the medical take.
5	Myocardial Ischaemia National Audit Project (MINAP) April 2023 - March 2024	Some of the metrics are improving ‘percentage seen by Cardiologist/ receiving specialist cardiology care’ and the ‘percentage admitted to Cardiac Ward’. Echocardiology is improving year on year for ST-segment elevation myocardial infarction (STEMI) patients. (Angiography is out of WHH control, as this service is not provided by the Trust. Liverpool Heart and Chest Hospital should be doing the angiography: therefore, this metric belongs to them). Referrals to Cardiac rehabilitation remain high. Although it was noted that the data presented is historic data (2022 – 2023). However, there are no major patient safety concerns from this national audit. Action plan for improvement - • Early review by competent decision makers – confirm diagnosis of acute coronary syndrome (ACS) and decision about early invasive strategy. • Early treatment with secondary prevention – there is an ACS order set that can be used by the admitting medical team to prescribe all appropriate medication. • Early referral to tertiary centre – to meet 72hr target.
6	National Paediatric Diabetes Audit (NPDA) 1 April 2023 - 31 March 2024	The Paediatric Diabetes Unit is doing well and is not an outlier. The median HbA1C and percentage of patients with better glycaemic control (percentage patient < 58 mmol/mol) is

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		improving year on year. The median HbA1c is better than national and regional average. Children and young people have better access to diabetes technology for Continuous Glucose Monitoring (CGM) and has improved the position with increased numbers of Hybrid Closed Loop (HCL) technology post audit submission. Currently the rate for HCL is better than the national average. Action plan for improvement – • Improve annual care process completion rates for Urine albumin-creatinine ratio (uACR) and Eye screening by generating Quality Improvement project.
7	National Cancer Audit Collaborating Centre (NATCAN) Non-Hodgkins Lymphoma (NHL) 1 January 2022 - 31 December 2023	From this audit, it is clear, that the WHH patients with NHL receives the appropriate management and the appropriate treatment for their diseases. No delays in diagnosis or management were found from this audit and the patients' 1- and 2-years survival was comparable to the national standards. Action plan for improvement – • Multidisciplinary Team (MDT) Co-ordinator will ensure that all the appropriate data will be uploaded to somerset. • Clinical Nurse Specialist (CNS) contact information will be given to NHL patients who require only monitoring (no active treatment) and also CNS will identify new NHL patients and will contact them for an initial introduction.
8	National Audit of In-patient Falls (NAIF) 1 January 2024 - 31 December 2024	The national falls audit was only related to 6 patients. This was presented as a 'hot topic' at the Quality Academy Sub Committee (QASC). Action plan for improvement – • Arrange for the SWARM* huddle to be added to EPR. • Complete a local Trust wide falls audit (with a greater number of patients). • Complete thematic review of falls with moderate or severe harm from April 2025 to March 2026. • Emphasize the importance of adhering to least restrictive practice principles (in relation to delirium) via the Trust-wide safety briefing.

Details of actions taken or being taken to improve the quality of local services and the outcomes of care.		
No.	**Title of National Clinical Audit reports received in 2024/25**	**Improvement Action: Details of actions taken or being taken to improve the quality of local services and the outcomes of care.**
		*SWARM is one of the learning tools that can be used for the Patient Safety Incident Response Framework (PSIRF)
9	National Respiratory Audit Programme (NRAP) Pulmonary Rehabilitation April 2024 - March 2025	The Trust is meeting recommended services and, therefore, in a good place despite the limited resources available. However, we have noted that it's taking too long to identify patients with Field Safety Notices (FSN) issues. Action plan for improvement – To investigate with the national body the possibility of including identifying devices with field safety notices in the audit tool.
10	National Comparative Audit of Bedside Transfusion Practice 2024 (Re-audit)	This audit showed marked improvements compares to the initial 2011 audit and received the Clinical Audit Award of Excellence*. Earlier recognition of transfusion reactions: WHH's strong performance in pre, mid and post transfusion observations (all 100%). Improved patient safety identification checks -national report for 2011-97.7% Vs national report for 2024-100% Elements of component checking 2011-40% vs 2024-100% Bedside checking 2024-100% (only data for 2024). However, it was felt that further improvement could be made: Action plan for improvement – • Discuss with Hospital Transfusion Committee whether a formal bedside checklist should be introduced.

Local clinical audit is important in measuring and benchmarking clinical practice against agreed markers of good professional practice stimulating changes to improve practice and re-audit to determine that service improvements have been made and sustained.

The reports of 16 local clinical audits were reviewed by the Trust in 2025-26 with actions in progress to improve the quality of healthcare provided. The table below details a sample of local audits undertaken.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
Clinical Support Services		

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
1.	Inhaler Prescribing for Asthma and COPD: Guideline Adherence, Cost and Environmental Impact	Key learning from the audit was that improved education and multidisciplinary collaboration are essential to promote environmentally sustainable and cost-effective inhaler prescribing. Action plan for improvement – • Promote Maintenance and Reliever Therapy (MART) Therapy - Encourage evidence-based use of MART regimens in asthma where clinically appropriate to improve asthma management in line with NICE recommendations. • Develop Trust Asthma Guidelines - Align with NICE NG245 to ensure prescribing reflects current evidence and sustainability priorities OR await updated Cheshire and Mersey Asthma Guidelines. • Prescriber and Patient Education - Provide training on updated guidelines, MART and sustainable prescribing to increase knowledge, confidence and adherence to new prescribing approaches. • Increase awareness on sustainable prescribing and recycling of inhalers. • Prescriber and Patient Education - Patients prescribed Metered Dose Inhalers (MDI) to be changed to DPI alternatives. Pharmacists to question if patients could be swapped to Dry Powder Inhalers (DPI) inhalers.
2.	Interventional Radiology WHO and Local Safety Standards for Invasive Procedures (LocSSIPs) Re-Audit	2 of the 4 standards shown improvement compared to the 2024 audit: No left/right laterality abbreviations used - improvement from 88% to 96%. Two signatures present on LocSSips – person completing and second checker improvement from 88% to 93%. Action plan for improvement – • Feedback to staff at Interventional Radiology (IR) staff meeting that they must ensure that two different staff members sign the form/sign out section must be completed and that they must not use abbreviations
Corporate Services		
3.	Trust wide Discharge Planning	Some improvements were seen when comparing to the 2022/23 audit: Estimated date of discharge set at post take ward round 88% compared to 82%

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Discharge summary written prior to discharge 89% compared to 64% The use of the Electronic Patient Record (EPR) discharge checklist was not utilised within the trust continuously. It would appear our staff are not discussing partaking discharge planning conversations at the time they are admitting patients to the areas. This proceeds as a delay and patients only find out their discharge date on the actual date of discharge. Action plan for improvement – • Review of the current EPR checklist to ensure this is easily accessible for staff and completed at the point of discharge • Training and education to be provided at ward level on Discharge Planning Policy and SOP, including use of Discharge checklist • Easily accessible information available on every inpatient area regarding Trust Discharge Planning Policy, to support non-Trust staff • Confirmation of equipment/ aids/ adaptions in place prior to discharge • Suitable clothing to be available for patients to ensure safe discharge of patients leaving the trust
4.	Contextual Safeguarding Screening Re-Audit	3 of the 4 standards shown improvement compared to the 2023 audit: Screening tools considered when providing care for those patients with three or more risk factors; 50% compared to 14%. Screening tools completed when providing care for those patients with three or more risk factors; 50% compared to 3%. Screening tools submitted to the local authority for further assessment and screening; 25% compared to 3% Action plan for improvement – • All staff to ensure they are compliant at the appropriate level of training in relation to Contextual Safeguarding and Safeguarding Children. • Where missed opportunities are identified retrospectively, staff involved to access safeguarding supervision. • WHH to support the local Contextual Safeguarding Operational groups (Warrington and Halton). This

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		will ensure appropriate information sharing with partner services.
		Digestive Diseases
5.	Re-Audit of Frailty Score Assessment in the Management of Breast Cancer Patients Aged over 70 Following Implementation of Changes from Previous Audit	The 'Audit and Re-audit' reinforced that early frailty assessment is both feasible and valuable in guiding treatment decisions. Moving forward, it's clear that continued efforts are needed to embed frailty screening as a routine part of breast cancer care. Action plan for improvement – • Identifying the level of frailty at first presentation. • Develop a standardized definition of and cutoff points for frailty. • Incorporate frailty concepts into training curricula. • Incorporate screening measures as part of routine practice.
6.	Patient Controlled Analgesia (PCA) Monitoring Compliance Audit	The audit highlighted concerns that the monitoring was not being completed correctly and the PCA paper chart was not always signed which is a patient safety issue. Action plan for improvement – • All nursing staff who manage patients with a PCA to attend training delivered by In-Patient Pain Service at least once every 2 years – to be made role specific mandatory. Development of new paper PCA charts highlighting the need to prescribe electronically.
		Integrated Medicine & Community
7.	Use of Antipsychotics and Benzodiazepines in People Experiencing Delirium	The audit showed evidence of improvement in investigating and treating underlying causes of delirium. Significantly fewer cases documenting distress, agitation, or behaviours that challenge. Action plan for improvement – • Safeguarding team to provide training on MCA appropriate to job role. • Update rapid tranquilisation policy and dementia and delirium guideline. • Contact medical lead for discharge letters and explore potential options to improve documentation. – co-author mortality newsletter.
8.	Bedside Table Accessibility for Hydration	Before carrying out this audit, it was expected that most patients would be satisfied with their bedside hydration. While this was largely the case, a few unexpected issues came up.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		Action plan for improvement – • Bedside table positioning: After any care activity (e.g., examinations or bed-making), ensure bedside tables are returned to a position accessible to the patient, with compliance checked during daily ward rounds. • Equipment checks and adjustments: Inspect all bedside tables at the start of each shift to confirm wheels and height adjustments are working, promptly report and replace any faulty equipment, and adjust table height to suit each patient's needs. • Table clearance and accessibility: Ensure bedside tables are kept free of unnecessary items and verify at least once per shift that essential items (e.g., drinks, call bell, personal items) remain within easy reach of the patient.
Medical Care		
9.	Re-Audit to Review the Standards of Documentation Related to Intra-Articular Injections and Aspirations in Rheumatology Joint Injection Clinics	There was an improvement in compliance to the standards of documentation on intra-articular joint injections. The current results compared to the previous year: Documented consent for all patients undergoing joint injection/aspiration:100% vs 100% Documentation of risks and benefits explained to patients before joint injection: 85% vs 82% Action plan for improvement – • LocSSIP forms to be completely filled out and placed inside the patient folder in joint injection clinics. • Forms will be made available in all the joint injection clinics.
10.	Re-audit: Utilisation of the Newly Established T1 Reference Range in Cardiac MRI Reports	There was an improvement in compliance to the standards of documentation on intra-articular joint injections. The current results compared to the previous year. Action plan for improvement – • Engage with all professionals involved in reporting cardiac MRI within our Trust through multiple communication channels to ensure awareness of the newly established T1 reference range.
Surgical Specialities		
11.	Re-audit of Compliance to NICE Venous Thrombo Embolism	The re-audit shown some improvements:

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
	(VTE) Guidelines in Patients Admitted Under Urology	A proportion of patients assessed for VTE on admission has improved after alteration of the urology handover sheet. The average length of time between admission and assessment also improved and is now within NICE guidance. Action plan for improvement – • Standardized checkbox to be added to urology list, for those patients are admitted under urology
12.	Outcomes Following Metatarsophalangeal Joint (MTPJ) Fusion	The audit shown the importance of using different measuring tools when assessing the overall success of a surgical procedure. By using two PROMs measures allowed us to get an understanding of how the patient views their own outcomes following the surgery and how it has impacted on their life. Looking at the union rates ensure that the outcomes of full bony union at the 1st MTPJ is achieved following the surgery. Action plan for improvement - not required.
	Urgent & Emergency	
13.	Audit of Management of Allergic and Anaphylactic Reactions in The Paediatric Emergency Department (PED)	Documentation can be poorly written and needs to be made simpler, so it is easier for clinicians to understand. Easy to follow flow charts and checklists will also ensure things aren't missed. Action plan for improvement – • Ensure all PED clinicians are aware of the guideline and the importance of clear documentation by sending out an email reminder. • Clarify the treatment pathway by updating the trust guideline with the new RCUK guidelines. • Ensure all clinicians can follow the trust guidelines by creating a summary sheet • Ensure PED clinicians are aware. • Revise the guideline, making it easier to follow.
14.	Audit of Adherence to NICE Clinical Guidelines for Self-Harm	This audit has shown that in times of high clinical pressure, the mandatory forms in the paediatric emergency department are completed, such that the majority of the

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		guidelines are followed for important issues such as Self-Harm. Action plan for improvement – • Develop a template to be used when taking a Self-Harm history. This could include the patient's current emotional state while assessed and details regarding how the patient feels about medical and mental treatment. • Furthermore, it may be beneficial to carry out this project over a longer timeframe for example, analysing data for all of 2025 to account for any seasonal variation in results.
Women & Children		
15.	Re-audit: Timely Multidisciplinary Involvement in the Care of Antenatal, Intrapartum and Postnatal Women	Compared to the initial audit in 2023: MDT participation at AM handover, 89% vs 77% in initial audit. Minimum twice daily ward round and must be all members of MDT present, 81% vs 67% in initial audit. AM: all postnatal readmissions reviewed, 88% vs 70% in initial audit. Action plan for improvement – • To start an electronic data base of the staff members, present at the MDT hand over. • Ensure all Postnatal readmissions are marked on Ward C23 Board and inform C23 staff. • Resident doctor staffing levels during the daytime to ensure sufficient coverage.
16.	Re-audit of Paediatric and Neonatal Handover	Compared to the initial audit that was carried out in 2020 there was an improvement in compliance against some standards such as finishing on time and overall length of handover. However, still noted a need for improvement in areas such as handovers starting on time, including opportunities for teaching, involvement of the MDT, system risk assessment (or safety brief). Action plan for improvement – • Raise awareness - Email to be sent to departments who regularly refer to paediatrics such as paediatric ED and maternity to remind them of the protected handover times.

Details of actions taken to improve the quality of local services and the outcomes of care		
No.	**Local Clinical Audits presented for assurance 2023/24**	**Details of actions taken to improve the quality of local services and the outcomes of care**
		• Raise awareness - Email switchboard to inform of protected handover times and ask them to let those from outside times know if they are calling due to protected handover • Message to be put in nursing safety brief reminding ward staff of protected handover times, appropriate interruptions and escalation procedure • Print out handover checklist and keep in handover room • Encourage ongoing use of handover checklist by regular reinforcement at morning and evening handovers by consultant body. • Handover expectations to be included in information given to new rotating drs at each rotation. Such as timely attendance, completion of jobs, printing handover lists.

The Clinical Audit Award of Excellence is the Trust based scheme that awards those clinical audits that meet defined criteria. This includes adhering to the Clinical Policy in conducting the clinical audit and in promoting learning outcomes.

2.7 Information on Participation in Clinical Research Development 2025-26.

Introduction

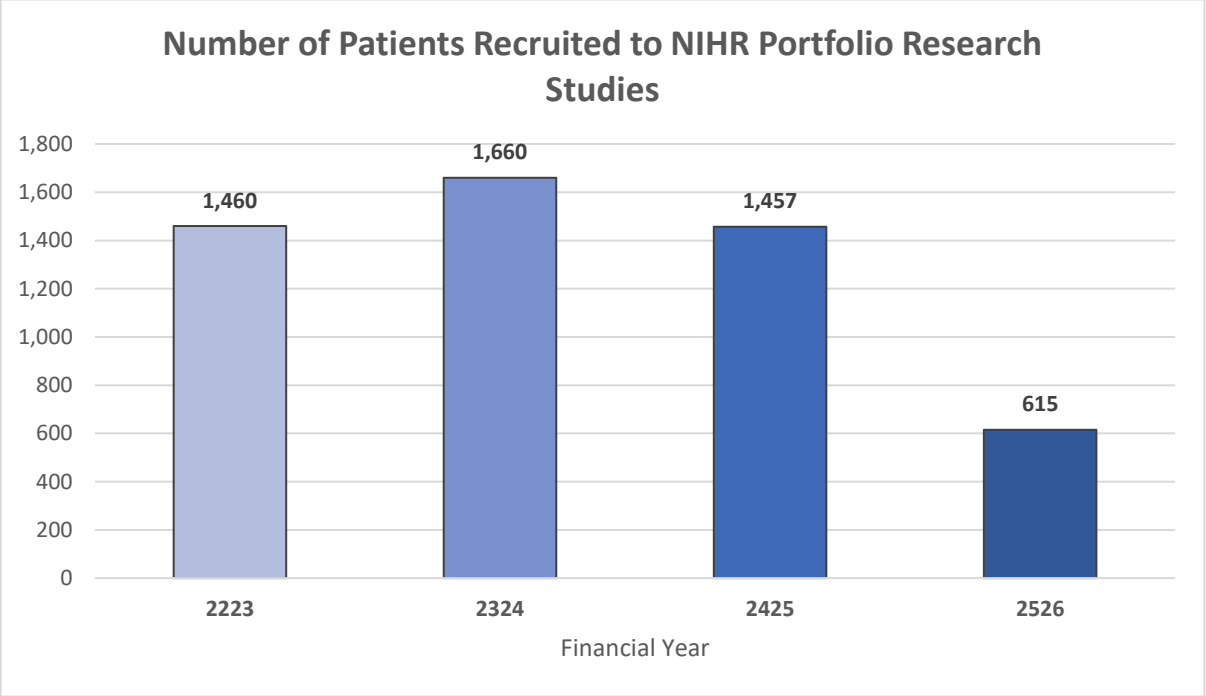
Clinical Research is vital to improve the knowledge needed to develop the current and future quality of care for patients. Carrying out high quality research gives the NHS the opportunity to minimise inadequacies in healthcare and improve the treatments patients receive. The Trust is only involved with research studies that have received a favourable opinion from the Research Ethics Committee within the National Research Ethics Service (NRES), signifying the research projects are of high scientific quality and have been risk assessed.

The Research, Development and Innovation Department (RD&I) forms part of the Quality Academy and is committed to providing patients with the opportunity to participate in research if they wish. The aim is to ask all eligible patients if they would like to participate in a clinical trial.

Overview of Research Activity

The number of patients participating in research approved by a research ethics committee was 615 across 28 studies. This includes those involved in National Institute for Health and Care Research (NIHR) and non-NIHR supported research studies, however none of these studies were delivered in FY25-26.

The NIHR Portfolio Study data for FY25-26 was not signed off nationally at the time of reporting. Therefore, the participant recruitment figure is un-validated at this time.



Data Source: NIHR Open Data Platform (rdn.uk.qlikcloud.com) accessed 22/04/2026. Non-Portfolio data extracted from Local Portfolio Management System 22/04/2026.

The NIHR portfolio studies are high quality research that have full funding and have undergone a rigorous peer review to be adopted onto the portfolio.

Participation in clinical research demonstrates the commitment of Warrington and Halton Teaching Hospitals, NHS Foundation Trust to improving the quality of care offered, contributing to wider health improvement.

Warrington and Halton Teaching Hospitals NHS Foundation Trust was involved in recruiting to 28 clinical research studies during 2025-26, covering 14 NIHR Portfolio specialities as outlined in the Table below.

Study Type	Study Sponsor	NIHR Portfolio Speciality	Short Name	Study Title	Recruitment
Commercial	SANOFI	Gastroenterology and Hepatology	DRI16804	A randomized, double-blind, placebo-controlled dose-finding study to assess the efficacy and safety of SAR443122 in adult patients with moderate to severe	1

				ulcerative colitis	
Commercial	MODERNA, INC.	Infection	Nova301 - mRNA-1403-P301	A Phase 3, Randomized, Observer-blinded, Placebo-Controlled Study to Evaluate the Safety and Efficacy of mRNA-1403, a Multivalent Candidate Vaccine to Prevent Norovirus Acute Gastroenteritis in Adults ≥18 Years of Age	83
Commercial	CIDARA THERAPEUTICS, INC.	Infection	The ANCHOR Study	A Phase 3 Randomized, Double-Blind, Placebo-Controlled, Multicenter Study to Evaluate the Efficacy and Safety of CD388, a Novel Long-Acting Antiviral Conjugate, for the Prevention of Influenza in Adults and Adolescents at Increased Risk of Developing Influenza Complications	30
Non-Commercial	University of Leicester	Ageing	CHARMER WP4 Definitive Trial	Comprehensive Geriatrician led Medication	323

				Review (CHARMER) - Work Package 4 Definitive Trial	
Non-Commercial	University College London	Anaesthesia, Perioperative Medicine and Pain Management	Perioperative Quality Improvement Programme: Patient Study	Improving perioperative care through the use of quality data: Patient Study of the Perioperative Quality Improvement Programme	18
Non-Commercial	University College London	Anaesthesia, Perioperative Medicine and Pain Management	SONAR 1	Snapshot Obstetric National Anaesthetic Research Project 1 (SONAR-1)	12
Non-Commercial	University of Oxford	Children	Evaluating SLC support at the 2-2½ yr Healthy Child review	Evaluating speech, communication, and language support at the 2-2½ year Healthy Child review (ESCALATER)	2
Non-Commercial	ALDER HEY CHILDREN'S, NHS FOUNDATION TRUST	Children	PADDINGToN-2	Parent co-Designed Drug Information for parents and Guardians Taking Neonates home (PADDINGToN 2) – a Feasibility Study	3
Non-Commercial	University of Birmingham	Critical Care	ABBRUPT	A randomised controlled trial to investigate	2

				clinical and cost effectiveness of Amiodarone vs Beta Blockade for new onset atrial fibRillation in icU - a Pragmatic study	
Non-Commercial	University of Warwick	Critical Care	Awake Prone	CoReCCT: The Awake Prone Study: Awake prone positioning in patients with acute hypoxaemic respiratory failure not due to COVID-19: A randomised controlled trial	5
Non-Commercial	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Critical Care	Family involvement in treatment decisions for ICU patients aged >75yrs	The VIP-3 study: Decision-making in the older ICU patient: How are family meetings implemented across diverse European cultures?	9
Non-Commercial	LOTHIAN	Critical Care	GenOMICC	Genetics of susceptibility and mortality in critical care (GenOMICC)	29

Non-Commercial	UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	Critical Care	MOSAICC	Evaluating the clinical and cost-effectiveness of Sodium Bicarbonate administration for critically ill patients with Acute Kidney Injury and metabolic acidosis	6
Non-Commercial	Imperial College of Science, Technology and Medicine	Critical Care	SepTiC	Sepsis Trials in Critical Care	6
Non-Commercial	University of Oxford	Critical Care	Threshold for Platelets Study (T4P)	The Threshold for Platelets (T4P) study: a prospective randomised trial to define the platelet count below which critically ill patients should receive a platelet transfusion prior to an invasive procedure	3
Non-Commercial	Imperial College of Science, Technology and Medicine	Diabetes, Metabolic and Endocrine	DRN 552 (Incident and high-risk type 1 diabetes cohort – ADDRESS-2)	An incident and high-risk type 1 diabetes research cohort - After Diagnosis Diabetes Research Support System-2 (ADDRESS-2)	16
Non-Commercial	University of Birmingham	Ear, Nose and Throat	STARFISH Trial	A randomised controlled	3

				trial of Steroid Administration Routes for Idiopathic Sudden sensorineural Hearing loss	
Non-Commercial	GREATER GLASGOW AND CLYDE	Ear, Nose and Throat	The TYPHOON Study	The TYPHOON Study: Tonsillectomy Postoperative Haemorrhage Outcomes and Observations National Cohort Study	5
Non-Commercial	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	Gastroenterology and Hepatology	ColoCap	ColoCap: determining the diagnostic accuracy of colon capsule endoscopy compared to standard colonoscopy in patients at risk of colorectal disease.	5
Non-Commercial	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Gastroenterology and Hepatology	IBD Bioresource	The UK Inflammatory Bowel Disease Bioresource: Progressing from Genetics to Function and Clinical Translation in Crohn's Disease & Ulcerative Colitis	3
Non-Commercial	University of Oxford	General Practice	DURATION UTI	Impact of duration of antibiotic	14

				therapy on effectiveness , safety and selection of antibiotic resistance in adult women with urinary tract infections (UTI): a randomised controlled trial	
Non-Commercial	University of Manchester	Musculoskeletal and Orthopaedics	Toxicity from biologic therapy (BSRBR)	Prospective observational study of the long-term hazards of biologic therapy in rheumatoid arthritis	6
Non-Commercial	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	Ophthalmology	TAGS GEN	Treatment of Advanced Glaucoma Study (TAGS) - profiling the genetics of advanced glaucoma	1
Non-Commercial	Imperial College of Science, Technology and Medicine	Reproductive Health and Childbirth	Early verus late glucose monitoring in recurrent gestational diabetes	An observational nested multicenter cohort study of early versus late monitoring among pregnant women with a history of gestational diabetes	3
Non-Commercial	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Reproductive Health and Childbirth	MiNESS 20-28	Mothers working to prevent early stillbirth study: MiNESS 20-28	2

Non-Commercial	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	Reproductive Health and Childbirth	The iHOLDS Trial	High or low dose Syntocinon for induction of labour in nulliparous women: a double blind, randomised controlled trial	2
Non-Commercial	University of Manchester	Reproductive Health and Childbirth	The Tommy's Project	The Tommy's Project - a coordinated antenatal and tissue data study of pregnancy outcome and related disease	20
Non-Commercial	University of Nottingham	Stroke	Pharyngeal Electrical stimulation (PES) for Post Stroke dysphagia (PSD	Pharyngeal Electrical stimulation for Acute Stroke dysphagia Trial (PhEAST)	3

Data Source: NIHR Open Data Platform (rdn.uk.qlikcloud.com) accessed 22/04/2026.

New studies opened in FY25-26 are detailed in the tables below.

	Commercial		
	FY24-25	**FY25-26**	**% Improvement**
Number of Studies Opened	2	1	-50.00%
Number of Participants Recruited	118	30	-74.58%

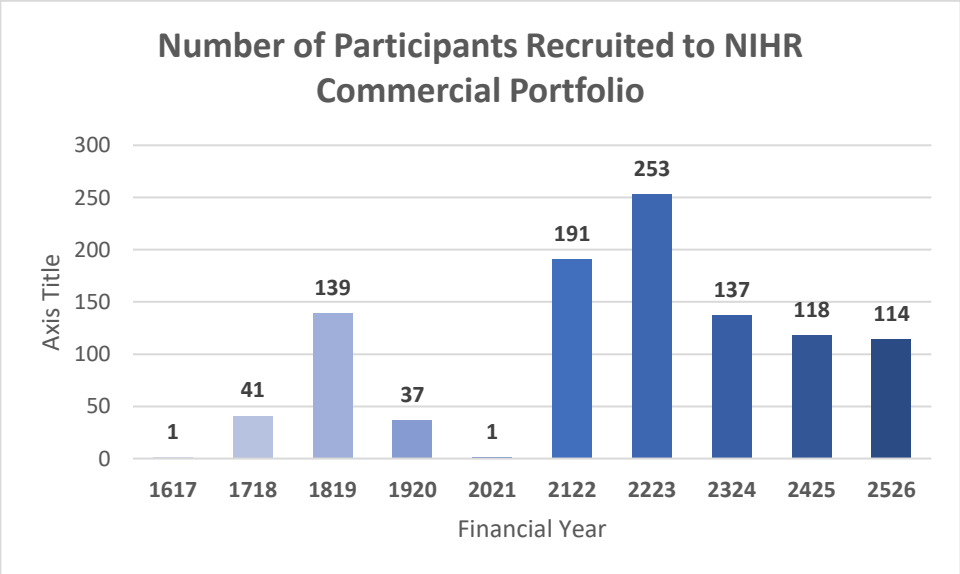
	Non-Commercial		
	FY24-25	FY25-26	% Improvement
Number of Studies Opened	7	16	128.57%
Number of Participants Recruited	1187	72	-93.93%

	Non-Portfolio		
	FY24-25	FY25-26	% Improvement
Number of Studies Opened	1	0	-100.00%
Number of Participants Recruited	68	0	-100.00%

Data Source: NIHR Open Data Platform (rdn.uk.qlikcloud.com) accessed 22/04/2026. Non-Portfolio data extracted from Local Portfolio Management System 22/04/2026.

The data reinforces that there have been fewer recruits across newly opened studies delivered by WHH in the non-commercial portfolio, despite opening more than twice as many new studies as the previous financial year but registering less than 10% of the recruitment.

This is a challenging position that WHH will address through the initiation of large-volume recruiting studies, ensuring more patients and service users are offered research they are potentially eligible for.



Data Source: NIHR Open Data Platform (rdn.uk.qlikcloud.com) accessed 22/04/2026.

Recruitment to NIHR Commercial Portfolio studies have maintained a steady rate, despite an overall lower level of recruitment than recent financial years, representing 36.1% of total recruitment. This is compared to 8.6% (118/1365) in FY24-25.

Improving the offer of research opportunities to patients

Scoping for new studies

RD&I scope out new studies for WHH through an "expressions of interest" portal and proactive approaches to Research Teams and commercial sponsors. NIHR Portfolio studies are facilitated by the NIHR RDN with an app called the "Site ID Portal" for commercial studies open to expressions of interest, launched in February 2025.

The data contained within the Site ID Portal is accessible to partner organisations by request only and data was not available at time of writing. This report will therefore detail non-commercial expressions of interest only.

101 non-commercial studies were assessed for suitability with 22 resulting in an expression of interest being submitted in FY2025-26.

Source for expressions of interest data: Locally held records accessed 10/04/2026.

Status	Study Type	No Studies
Expression of Interest Submitted	Non-Commercial	22

WHH did not express interest in 73 of the studies offered, with the following table categorising the reasons why these studies were not deemed suitable.

Declines for Non-Commercial NIHR Portfolio Studies

Decline Reason	No of Studies
Clinical capacity - departmental	2
Deadline passed	3
Lack of pt pop	7
No interest	23
No pt population	4
No spec service	21
No specialist service	1
No suitable PI	2
PI capacity	4
R&D Capacity	1
Study Design	4
Withdrawn by Sponsor	1
Total	**73**

Recruitment Performance

Recruitment performance has been significantly lower than recent financial years. 1658 participants were recruited in last financial year compared to 615 in FY25-26. This is due to

the closure of multiple studies with high recruitment rates and volume. WHH have worked to secure a pipeline of non-commercial studies that will enable recruitment levels to recover.

Study Type	NIHR Portfolio Speciality	Short Name	Recruitment	% Total Recruitment
Non-Commercial	Ageing	CHARMER WP4 Definitive Trial	323	52.5%
Commercial	Infection	Nova301 - mRNA-1403-P301	83	13.5%
Commercial	Infection	The ANCHOR Study	30	4.9%
Non-Commercial	Critical Care	GenOMICC	29	4.7%
Non-Commercial	Reproductive Health and Childbirth	The Tommy's Project	20	3.3%
Non-Commercial	Anaesthesia, Perioperative Medicine and Pain Management	Perioperative Quality Improvement Programme: Patient Study	18	2.9%
Non-Commercial	Diabetes, Metabolic and Endocrine	DRN 552 (Incident and high-risk type 1 diabetes cohort – ADDRESS-2)	16	2.6%
Non-Commercial	General Practice	DURATION UTI	14	2.3%
Non-Commercial	Anaesthesia, Perioperative Medicine and Pain Management	SONAR 1	12	2.0%
Non-Commercial	Critical Care	Family involvement in treatment decisions for ICU patients aged >75yrs	9	1.5%

Data Source: Non-Portfolio data extracted from Local Portfolio Management System 22/04/2026.

WHH recruited to 28 studies in FY25-26, with 10 studies providing 90.1% of the total recruitment. As reported earlier, commercial recruitment remains relatively static at 114 compared to 118 in FY24-25. This demonstrates a

Developing Principal Investigator Capacity

The capacity of the Trust to conduct research is heavily influenced by the number of Principal Investigators (PIs) employed. To have a sustainable research workforce, the PI pool needs to be both rich and diverse. Improvement to the overall capacity of the Trust for research has been facilitated by:

- R&D conducting regular reviews of Programmed Activity allocations to identify areas where there is potential for PI growth.
- PI Forum held every two months to encourage the growth of a community of practice
- Creation of the Research Oversight Sub-Committee alongside the development of Sponsorship capabilities.

Improving Access to Clinical Trial Opportunities - Pathway to Research

In 2023, the Pathway to Research registry was launched to connect patients directly with research opportunities. This initiative allows patients to access new studies in a timely manner while providing the Trust with an additional avenue for participant recruitment.

To date, 331 individuals have consented to join the registry, including 42 in FY25-26.

<u>Learning from Experience</u>

My Research Experience
My Research Experience (formerly Participant Research Experience Survey) is conducted by the National Institute for Health and Care Research (NIHR) Research Delivery Network (RDN) and gathers valuable feedback to enhance the experience of research participants.

In FY25-26, WHH received 39 responses from My Research Experience. Responses indicate a largely positive experience with research and 90% would consider taking part again.

The survey contains a free text response for positive and negative feedback to be provided about participants' research experience. The word cloud below illustrates the focus of the positive comments of staff being friendly, informed, professional and caring. Participants also reported feeling that taking part was easy, and that contributing to research is valuable.

Data source: NIHR PRES Dashboard (rdn.uk.qlikcloud.com) accessed 22/04/2026. Word cloud created with wordart.com

The negative feedback was limited with 5 responses which have fed into improvements to the service. Key areas for enhancement include improving the hospitality facilities, difficulty of access with roadworks around the hospital and a more personal attitude.

One response highlighted a negative experience that was acted on to improve the experience of future participants for a particular trial. This resulted in improvements to patient information leaflets and reinforced training for members of staff. All identifying details have been removed to preserve anonymity.

Impact

Commercial Research Delivery Centres (CRDC)

Cheshire and Merseyside now host two NIHR Commercial Research Delivery Centres (CRDC), one hosted by the NHS University Hospitals of Liverpool Group (UHLG) and the other by General Practices across Cheshire and Merseyside.

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) will play a vital role as part of these newly established structures.

The CRDCs, funded through a £100 million government-private initiative, will accelerate commercial studies across Cheshire and Merseyside, enabling rapid access to innovative treatments through clinical trials. WHH, alongside other key organisations in the region, will contribute to the delivery of cutting-edge research in areas such as cancer, respiratory illness, obesity, and infectious diseases. The UHLG-hosted CRDC hold regular meetings with partner organisations and are working toward truly collaborative commercial study delivery.

Strategic Funding Award

The NIHR RDN opened a funding call for projects aligning with the RDN's strategic objectives. WHH applied for a total of £284,401 as the lead organisation on three submissions:

1. Funding for an ambitious collaborative project between WHH, Runcorn PCN and Wellbeing Enterprises CIC to improve research awareness, install social prescribers as research link champions and install an infrastructure for research within Runcorn PCN (£24,374/£144,672)
2. Funding for a new role for community research delivery in anticipation of the acquisition of Bridgewater Community Healthcare (BCH) NHS Trust (£53,554/£74,688)
3. Funding for paediatric research nurse and research midwife time (£0/£65,041)

Two of these projects were awarded with funding arriving in FY26-27.

Modifications made to the application:

1. Community engagement element of the programme has been funded with Wellbeing Enterprises CIC leading on this aspect. Engagement will include the training of social prescribers and research links, training of professional and lay research champions and the hosting of focus groups and a research roadshow. The funding envelope is for a period of 12 months.
2. This submission requested funding for 24 months but was awarded for 18 months.
3. This submission did not receive funding.

Primary Care

WHH continues to engage with Primary Care and meets regularly to identify opportunities for alignment, streamlined infrastructure and collaborative research delivery across both Warrington and Halton boroughs.

The strategic funding award from the RDN will help to establish closer working relationships with Runcorn PCN practices.

Research Oversight Sub-Committee & Development of Sponsorship Capabilities

WHH has installed governance processes to enable the Sponsorship of homegrown studies. Sponsorship activity is reported to the Research Oversight Sub-Committee. As a Sponsor organisation, WHH can now support staff to design their own research, directly for the benefit of WHH patients and service users.

As a Sponsor, WHH has now submitted one study to the HRA for regulatory and ethical approval: Assessment of the geniohyoid muscle in critical illness (IRAS 341070) with Dr Peter Turton, Consultant in ITU, as Chief Investigator. Approval was granted on 20 January 2026.

Developing Sponsorship capabilities will enable access to income streams based on specific grant funding, however this is a medium- to long-term goal.

2.8 Information on the use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework 2025-26

The Commissioning for Quality and Innovation (CQUIN) payment framework aims to support the cultural shift towards making quality the organising principle of NHS Services. In particular,

it aims to ensure that local quality improvement priorities are discussed and agreed at Board of Directors level within and between organisations. The CQUIN payment framework is intended to embed quality at the heart of commissioner-provider discussions by making a small proportion of provider payment conditional on locally agreed goals around quality improvement and innovation.

A proportion of Warrington and Halton Teaching Hospitals NHS Foundation Trust's Foundation Trust's income is normally conditional on achieving quality improvement and innovation goals agreed as part of the contract.

During 2024/25, the national Commissioning for Quality and Innovation (CQUIN) scheme was paused. In response, NHS Futures published a suite of non-mandatory quality indicators that Trusts could adopt to support local quality improvement activity during this period. For 2025/26, Warrington and Halton Teaching Hospitals NHS Foundation Trust made a local decision to continue with those existing CQUIN indicators that were not routinely captured through established Trust governance and reporting mechanisms, to maintain momentum in continuous quality improvement.

Following review, the Trust has now determined that it will no longer operate within the CQUIN framework. All quality improvement activity will continue as business as usual and will be overseen and assured through existing governance and reporting structures, ensuring continued visibility, accountability and focus on improvement delivery.

CQUIN ID	CQUIN Title	Target	Compliance Quarter 1	Compliance Quarter 2	Compliance Quarter 3	Compliance Quarter 4- Prelim
01	Flu Vaccinations for frontline healthcare workers (annual CQUIN)	Min – 50% Max – 50%	N/A	N/A	46.20%	50.20%
03	Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	Min – 25% Max - 15% (NB lower % = more compliant)	38%	No Data Available	32%	24%
05	Identification and response to frailty in emergency departments (New)	Min – 10% Max – 30%	12%	12%	32.31%	47.05%

The following information provides details on the plans for improvements for those CQUINs that have not been achieved in 2025-26.

All CQUINs achieved during the final quarter 2025/26.

On 1 April 2026, Warrington and Halton NHS Foundation Trust formally integrated with Bridgewater Community Healthcare NHS Foundation Trust to establish North Cheshire and Mersey NHS Foundation Trust.

In light of NHS England's continued pause of the CQUIN framework, North Cheshire and Mersey NHS Foundation Trust has agreed to discontinue formal CQUIN delivery for 2026/27. However, work associated with the three CQUINs that remained in scope during 2025/26 will continue to be progressed operationally and assurance will be provided through alternative established governance routes within the Trust.

2.9 Registration with the Care Quality Commission (CQC) and Periodic/Special Reviews.

Warrington and Halton Teaching Hospitals NHS Foundation Trust are required to register with the Care Quality Commission, and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Warrington and Halton Teaching Hospitals NHS Foundation Trust during 2025-26.

The Trust is registered to provide the following services:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and Midwifery Services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder, or injury

Warrington and Halton Teaching Hospitals NHS Foundation Trust have not been subject to any special reviews or investigations by the Care Quality Commission during 2024/25.

New Service Registered.

There were no additional services requiring registration during 2025/26. All notifications relating to changes at Director level were submitted.

CQC Engagement.

The Trust was last fully inspected in 2019, where it was rated as 'Good'. This was followed by a further announced inspection in September 2023 as part of the National Maternity Inspection Programme, during which Maternity Services were again rated as 'Good'.

No services within Warrington and Halton Teaching Hospitals NHS Foundation Trust were inspected by the Care Quality Commission during 2025/26.

During the reporting period 2025/26, the Trust underwent a separate inspection under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) in August 2025. These inspections assess compliance with statutory requirements relating to the safe use of ionising radiation, including governance arrangements, policies, procedures and staff competencies.

No rating is issued as part of this regulatory process, with any findings managed through regulatory feedback and Trust action plans where required.

The Care Quality Commission has continued its regulatory approach through quarterly engagement meetings with the Trust throughout 2025/26, aligned to the Single Assessment Framework.

Post CQC Inspection Activity.

The post-inspection action plan from the Trust's 2019 CQC inspection was completed in November 2020. Improvements and sustainability continue to be supported and monitored through the Quality Compliance Oversight Group (QCOG), chaired by the Chief Nurse.

All CQC matters, compliance and external inspections are monitored through QCOG, with escalation to the Quality Assurance Committee, which in turn provides assurance to the Trust Board of Directors.

2.10 Information on the Quality of Data.

High quality data, captured at the point of care, underpins the Trust's ability to deliver care that is both safe and efficient enabling learning and improvement to be focused and meaningful. This forms the basis of robust systems of business intelligence that are integral to our day-to-day work.

Improving data quality requires effort, resources, and commitment at all levels in the Trust and requires a focus on user behaviour and improving how staff interact with the Trust's Electronic Patient Record and core systems.

The Trust will be taking the following actions to improve data quality: the Trust is monitored internally, locally, and nationally on the clinical data it generates and publishes.

The obligations upon all Trust staff to maintain accurate records are:

- Legal (Data Protection Act 2018)
- Contractual (Contracts of employment)
- Ethical (Professional codes of practice)
- Regulatory (Care Quality Commission, Good Governance)

2.11 NHS Number and General Medical Practice Code Validity

Warrington and Halton NHS Foundation Trust submitted anonymised clinical data records for patients seen and treated during April – March 2025/26* and 2024/25** to the Secondary Uses Service (SUS) for inclusion in the National Hospital Episode Statistics which are included in the latest published available data at the time of writing this report. The Trust evidences a positive position when compared with the national average. This is provisional information released for NHS managerial/Operational purposes only, based on data published on 18/05/2025. The final published data position report for month 12 is due to be published on 08/06/2026 for the percentage of records and GP Practice Codes.

The percentage of records in the published data which included the Patient's valid NHS Number was as follows:					
National Data Set	**Trust Valid**	**National Average Valid**	**Date Range**	**A&E Type**	**Financial Year**
Admitted Patient Care *	100%	99.7%	Apr 2025-Mar2026		2025/26
Outpatient Care *	99.9%	99.8%	Apr 2025-Mar2026		
Accident and Emergency (A&E) Care *	99.7%	99.0%	Apr 2025-Mar2026		
Accident and Emergency (A&E) Care *	99.6%	97.5%	Apr 2025-Mar2026		
Admitted Patient Care **	99.90%	99.7%	Apr 2024 – Mar 2025		2024/25
Outpatient Care **	99.90%	99.7%	Apr 2024 – Mar 2025		
Accident and Emergency (A&E) Care **	99.50%	99.00%	Apr 2024 – Mar 2025	Type 1	
Accident and Emergency (A&E) Care **	99.40%	96.70%	Apr 2024 – Mar 2025	Type 3	
Data source provided from SUS – Cumulative year to date end of 2024/25					

GP Practice Codes The percentage of records in the published data which included the patient's valid General Medical Practice Code was:					
National Data Set	**Trust Valid**	**National Average Valid**	**Date Range**	**A&E Type**	**Financial Year**
Admitted Patient Care *	100%	99.8%	Apr 2025-Mar2026		2025/26
Outpatient Care *	100%	99.6%	Apr 2025-Mar2026		
Accident and Emergency (A&E) Care *	100%	99.7%	Apr 2025-Mar2026	Type 1	
Accident and Emergency (A&E) Care *	100%	97.5%	Apr 2025-Mar2026	Type 3	
Admitted Patient Care **	99.50%	98.20%	Apr 2024 – Mar 2025		2024/25
Outpatient Care **	100.00%	99.20%	Apr 2024 - Mar 2025		
Accident and Emergency (A&E) Care **	100.00%	99.70%	Apr 2024 – Mar 2025	Type 1	
Accident and Emergency (A&E) Care **	100.00%	97.90%	Apr 2024 – Mar 2025	Type 3	
Data source provided from SUS – Cumulative year to date end of 2025/26					

As of 01/04/2026, Warrington and Halton NHS Foundation Trust merged with Bridgewater Community Healthcare NHS Foundation Trust to become North Cheshire and Mersey NHS Foundation Trust.

North Cheshire and Mersey NHS Foundation Trust will be taking the following actions to improve data quality and validity where it does not achieve 100% completeness.

- The Trust's Data Quality Team will continue to work closely with operational teams to ensure accuracy and completeness of the Trust key systems.
- A data quality dashboard has further supported the monitoring of data capture completeness.
- The Data Standards and Assurance Group continues to focus on areas requiring improvement relating to general data quality, Trust key performance indicators, operational areas and finance and contract performance.
- As part of the Trust governance structure the Data Standards and Assurance Group reports into the Information Governance and Corporate Records Sub-Group which in turn provides assurance to the Quality Assurance Committee.
- A Data Quality Policy is in place which identifies clear roles- and responsibilities for data quality and is routinely reviewed to ensure that it supports reporting and statutory obligations around national datasets.

2.12 Information Governance Assessment Report 2025/26.

The Trust uses the NHS England Data Security and Protection Toolkit (DSPT) in conjunction with the Datix Risk Management system, the Trust's ISMS (Information Security Management System), and the IT Health Cyber Assurance and Compliance System to ensure that it has robust data security and protection standards in place. The use of these systems informs the work of its Information Governance and Records Sub-Committee which was established to provide assurance that effective data security best practice mechanisms are deployed at the Trust.

The Information Governance and Records Sub-Committee is accountable to the Quality Assurance Committee which is a sub-committee of the Trust's Board of Directors. The Trust's Senior Information Risk Owner (SIRO) chairs the Information Governance and Records Sub-Committee which is also attended by the Trust's Caldicott Guardian (Medical Director). The SIRO (Chief Information Officer) acts as the Trust's lead for information risk.

WHHs most recent Data Security and Protection Toolkit assessment was finalised by Mersey Internal Audit Agency (MIAA) in November 2025 as part of the trust's annual audit programme. WHH was the subject of a two-part Data Security and Protection Toolkit review conducted by MIAA from February to July 2025. MIAA assessed 12 outcomes, and found that, for 9 outcomes, the organisation has met the minimum achievement level. However, MIAA also found that 3 outcomes were rated as not meeting minimum achievement levels. MIAA assessed the risk in these areas as high.

In assessing the proposed DSPT submission for 12 outcomes MIAA concluded that 9 of the trust's proposed submissions aligned with their assessment. For the remaining 3 outcomes MIAA's rating did not align with the rating proposed by the Trust. This represents a medium level of deviation between trust's proposed DSPT submission and the assessment by MIAA. As a result, the MIAA confidence level in the veracity of the DSPT assessment made by the trust is medium confidence.

The current Data Security and Protection Toolkit status for Warrington and Halton Teaching Hospitals NHS Foundation Trust following submission of the December 2025 interim assessment submitted to NHS England is approaching standards. Plans for improvement are in place and have been provided to NHSE.

2.13 Payment by Results (PBR) Clinical Coding Audit.

During 2025/26, Warrington and Halton Teaching Hospitals NHS Foundation Trust have continued to strengthen the quality and reliability of coded clinical data, despite ongoing workforce challenges within the clinical coding profession. Targeted investment in staff development, digital solutions and assurance processes has enabled the Trust to maintain focus on data quality as a core enabler of patient safety, clinical effectiveness, and organisational learning.

Throughout the year, the Trust maintained strong engagement with clinicians to improve documentation quality, provided ongoing support to the Mortality Review Group, and continued validation of the recording and coding of patients with Learning Disabilities and/or Autism. Targeted specialty coding validations, sustained training and development for trainee and experienced coders, close working with Digital and Data Quality teams, and further expansion of digital operation notes have strengthened assurance, coding accuracy, and workforce resilience.

Through these actions, the Trust ‘s Clinical Coding service has maintained a strong focus on data quality improvement, strengthening internal assurance arrangements and supporting safe, and effective patient care.

2.14 Learning from deaths.

In March 2017, The National Quality Board of Directors issued "National Guidance on Learning from Deaths: a framework for NHS Trusts and NHS foundation Trusts on identifying, reporting, investigating and learning from deaths in care”. This guidance included the requirements that Trusts must publish a Learning from Deaths Policy, and that from December 2018 Trusts must collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board of Directors Meeting. This data must include the total number of inpatient deaths and those deaths that the Trust has subjected to structured judgement review. Of those deaths subjected to review.

Reducing mortality is a priority for the Trust and is focused through the Mortality Review Group (MRG). The Mortality Review Group performs in-depth investigations using the Structured Judgement Review methodology into groups of patients conforming to agreed criteria as defined within the Trust Learning from Deaths policy.

The Trust currently has 8 trained clinicians who are trained in the Royal College of Physicians Structured Judgment Review (SJR) method for recording deaths, mortality reviews and their outcomes. The Trust has developed an electronic system which logs Structured Judgement Reviews (SJR) electronically and triangulates findings with complaints, claims, inquests, Medical Examiner’s Office and clinical incidents. This facilitates richer learning across the Trust.

Mortality Meetings focus upon process and system change, with the aim of developing recommendations to prevent a similar adverse outcome in the future. Any actions and improvements that have been made by the Mortality Review Group are reported to the Patient Safety and Clinical Effectiveness Sub-Committee monthly and the Quality Assurance Committee quarterly.

From 1 April 2025 to 31 March 2026, 245 SJRs were completed. 2 PSII's (Patient Safety Incident Investigation) were carried out in relation to 1181 of the deaths. They occurred in each Quarter of that reporting period as follows:

- Quarter 1 - 73 SJRs completed and 2 Patient Safety Incident Investigation.
- Quarter 2 – 44 SJRs completed and 0 Patient Safety Incident Investigation.
- Quarter 3 - 53 SJRs completed and 0 Patient Safety Incident Investigation.
- Quarter 4 – 75 SJRs completed and 0 Patient Safety Incident Investigation

The Mortality Review Group alongside other modalities provides valuable feedback on all aspects of care and helps us to understand what we may need to improve upon. It also provides the opportunity to identify practice that has been effective and meaningful to our patients. In addition, the Mortality Review Group identify workstreams which ensures the learning is triangulated and themes identified. The Trust publishes their quarterly reports on Mortality Reviews on the Trust's website: https://www.www.nhs.net Board of Directors-meetings-and-papers

2.15 Reporting Against Mandated Core Quality Indicators - Prescribed Information 2025/26.

The 2012 Quality Account Amendment Regulations (10) state that Trusts are required to report against a core set of quality indicators using the following standardised statement set out as follows:

Where the necessary data is made available to the Trust by NHS Digital, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed in the tables below with:

- The national average for the data.
- The NHS Trusts and NHS foundation Trusts with the highest and lowest of the same, for the reporting period.
- Present, in a table format, the percentage/proportion/score/rate/number for at least the last two reporting periods.

Trusts are only required to include indicators that are relevant to the services they provide. Further information on these NHS Digital definitions can be accessed at www.digital.nhs.uk.

2.16 Summary Hospital-Level Mortality Indicator (SHMI).

The data made available to the Trust by NHS Digital is with regard to:

The value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period was:

Date Period	Trust	Banding	England Average	England Highest	England Lowest
December 2024 – November 2025	103.55	2	100.93	131.83	71.94
November 2023 – October 2024	105.13	2	100.36	129.85	69.67

November 2022 - October 2023	92.22	2	100.0	120.65	72.15
October 2022 – Sept. 2023	94.68	2	100.0	122.93	67.70
November 2021 - October 2022	97.41	2	99.93	124.70	62.26
November 2020 - October 2021	98.3	2	100.0	118.60	71.90
November 2019- October 2020	106.9	2	100	117.75	67.82
November 2018 - October 2019	106.89	2	100	120.12	68.48
October 2018 – September 2019	105.93	2	100	118.77	69.79
October 2017 – September 2018	109.92	3	100	126.81	69.17
July 2016 – June 2017	112.32	2	100	122.77	72.61
Data Source: Hospital Episode Statistics (HES) data www.digital.nhs.uk/SHMI *The most up to date data on NHS Digital for the period December 2024 – November 2025 published on 9 April 2026 is displayed.					

Warrington and Halton Teaching Hospitals NHS Foundation Trust consider that this data is as described for the following reasons:

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust-level across the NHS in England. This indicator is produced and published quarterly, as an official statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die at the Trust, or within 30 days of being discharged, and the number that would be expected to die, on the basis of average England figures. A number below 100 indicates fewer than the expected numbers of deaths, and a number above 100 would suggest a higher-than-expected number of deaths.

Trusts are banded 1-3 as follows:

1. The Trust's mortality rate is 'higher than expected'.
2. The Trust's mortality rate is 'as expected'.
3. Where the Trust's mortality rate is 'lower than expected'.

The Trust was categorised 'as expected' over the past 12 months.

The Trust continues to operate a well-established programme of monthly Mortality Review Group (MRG) meetings, providing assurance that mortality reviews are undertaken regularly and rigorously. Learning arising from MRG is routinely shared, monitored, and used to drive measurable improvements in patient care and clinical practice across the Trust.

2.17 Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.

Date Period	Trust	England Average	England Highest	England Lowest
December 2024 – November 2025	52%	45.05%	69%	17%
01 November 2023 – 31 October 2024	49%	44.65%	66%	17%

Date Period	Trust	England Average	England Highest	England Lowest
01 November 2022 – 30 October 2023	49%	42%	66%	16%
01 October 2022 – 30 September 2023	48%	42%	66%	15%
01 November 2021 – 31 October 2022	46%	41%	65%	12%
01 November 2020 – 31 October 2021	55%	40%	64%	11%
01 November 2019- 31 October 2020	45%	36%	59%	8%
01 November 2018 – 31 October 2019	41%	36%	59%	11%
October 2018 – September 2019	40%	36%	59%	12%
October 2017 – September 2018	34.3%	33.4%	59.5%	14.3%
July 2016 – June 2017	41.7%	31.1%	58.6%	11.2%
Data Source: Hospital Episode Statistics (HES) data www.digital.nhs.uk/SHMI *The most up to date data on NHS Digital for the period December 2024 – November 2025 published on 9 April 2026 is displayed.				

Warrington and Halton Teaching Hospitals NHS Foundation Trust consider that this data is as described for the following reasons:

This is a nationally accepted dataset which is submitted to the Department of Health at agreed frequency. The Trust is also able to extract this information from NHS Digital to facilitate further analysis.

2.18 Patient reported outcome measures (PROMs) for (i) groin hernia surgery, (ii)* varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery.

Patient Reported Outcomes Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.

***PROMs also exist for varicose vein surgery; however, the Trust does not undertake this procedure.**

This data is made available to the Trust by NHS Digital with regard to the Trust's patient reported outcome measures scores for— groin hernia surgery, varicose vein surgery, hip replacement surgery, and knee surgery, during the reporting period were:

Groin Hernia – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2016/17	100	0.036	0.086
April 2017-September 2017	78	0.019	0.089
2018/19	PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS		
2019/20			
2020/21			

2021/22	England Consultation on PROMs, collection of these procedures ceased on 1 October 2017.
2022/23	
2023/24	
2024/25	
2025/26	

Varicose Veins – Percentage of patients with improvement in EQ-5D health scores			
Year	Eligible Episodes	Trust	National Average
2016/17	100	0.036	0.086
2017/18	78	0.019	0.089
2018/19	The Trust has not had any eligible patients within PROMS since 2017/18 following the transfer of Vascular Services to Lancashire Teaching Hospitals NHS Foundation Trust.		
2019/20			
2020/21			
2021/22			
2022/23			
2023/24			
2024/25			
2025/26			

PROMS is currently covering 2 surgical procedures for hip and knee replacements; PROMS calculate the health gains after surgical treatment using pre- and post-operative surveys.

PROMs are collected by all providers of NHS funded care. They consist of a series of questions that patients are asked in order to gauge their views of their own health. Patients are asked to score their health before and after surgery. It is then possible to ascertain whether a patient sees a health gain following their surgery. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs HES data.

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	Trust	National Average
2016/17	0.036	88.2%
2017/18	0.019	89.4%
2018/19	0.500	89.7%
2019/20	0.474	89.4%
2020/21	In order to respond to the challenges posed by the coronavirus pandemic NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020/21 reporting period. A reduced service continued during the 2021/22 reporting period. This has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. In addition, it is possible that behaviours around activities relating to the completion, return and processing of pre- and post-operative questionnaires may have also been impacted when compared to earlier years data where behaviours and processes related to managing the current pandemic were not in place.	
April 2021 – March 2022 Finalised PROMs Published: 13 July 2023	0.420	89.8%

Hip Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	**Trust**	**National Average**
April 2022 – March 2023	Insufficient Records available	89.2%
April 2023 -March 2024	0.465	88.1%
April 2024 – March 2025	0.392	89.3%
April 2025 – March 2026	April 2025 - March 2026 PROMs data is unavailable until February 2027	
Data Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms		

Knee Replacement – Percentage of patients with improvement in EQ-5D health scores		
Year	**Trust**	**National Average**
2016/17	0.370	81.0%
2017/18	0.312	82.1%
2018/19	0.324	82.1%
2019/20	0.335	82.8%
2020/21	The Covid-19 Pandemic has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs HES data.	
April 2021 – March 2022	0.309	87.4%
April 2022 – March 2023	Insufficient Records available	81.6%
April 2023 - March 2024	0.282	80.4%
April 2024 – March 2025	0.301	81.5%
April 2025 – March 2026	HES data is not available for April 2025 - March 2026 PROMs until February 2027	
Data Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms		

Warrington and Halton Teaching Hospitals NHS Foundation Trust consider that this data is as described for the following reason:

- PROMs data is a nationally mandated dataset for NHS-funded care in England. Data are collected from patients by provider organisations, including NHS Trusts delivering eligible PROMs procedures, using pre- and post-operative questionnaires to measure health gain following surgical treatment. The data are processed by accredited suppliers and analysed, scored, linked (including to Hospital Episode Statistics), and published by NHS England.

2.19 Emergency readmissions to hospital within 30 days of discharge.

The data made available to the Trust by NHS Digital with regard to the percentage of patients aged (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital within 30 days of being discharged from a hospital that forms part of the Trust during the reporting period.

Year	Categories	(0 to 15 (%)	16 or over (%)
2018/19	Trust	10.8	13.0
	England Average	12.3	14.3
	England Highest	86.7	68.8
	England Lowest	1.9	2.7
2019/20	Trust	11.7	13.5
	England Average	12.1	14.2
	England Highest	63.5	50.7
	England Lowest	2.6	4.7
2020/21	Trust	11.2	15.3
	England Average	11.6	15.5
	England Highest	89.3	201.1
	England Lowest	4.9	3.4
2021/22	Trust	11.9	12.9
	England Average	12.1	14.1
	England Highest	57.3	167.4
	England Lowest	3.3	2.8
2022/23	Trust	11.6	14
	England Average	12.8	15
	England Highest	302.9	922.1
	England Lowest	1.9	1.3
2023/24	Trust	10.8	13.9
	England Average	12.4	14
	England Highest	151.7	136.6
	England Lowest	1.3	1.3
2024/25	Trust	12.2	14.2
	England Average	12.7	14.2
	England Highest	149.8	143.2
	England Lowest	1.0	0.6
2025/26	Data not yet published by NHS Digital expected November 2026		
***Data Source**: www. emergency-readmissions*-nhs digital			

Patients aged 0-15					**Patients aged 16+**			
Discharge period	**Spells**	**Readmitted**	**Readmission Rate**		**Discharge period**	**Spells**	**Readmitted**	**Readmission Rate**
2019/2020	8870	1100	12.4%		**2019/2020**	128740	18400	14.3%
2020/2021	6440	775	12.0%		**2020/2021**	76200	12125	15.9%
2021/2022	7625	940	12.3%		**2021/2022**	84225	11000	13.1%

2022/2023	7690	950	12.4%	**2022/2023**	87915	12980	14.8%
2023/2024	7590	860	11.3%	**2023/2024**	82855	12380	14.9%
2024/2025	7670	885	10.8%	**2024/2025**	69240	9270	12.4%
2025/2026	Data not yet available until November 2026			**2025/2026**	Data Not Yet Available until November 2026		
Data source: www. emergency-readmissions-nhs digital							

Warrington and Halton Teaching Hospitals NHS Foundation Trust consider that the data is as described and available for analysis at the time of writing this report and is influenced by the following:

- The data for both 0-15 and 16+ patients (include readmissions that were for any reason regardless of the original admission reason).
- The figures provided report on all admissions under 16 years of age to the Trust. It is difficult to give an accurate narrative as they consist of all three sites where young people may attend the Emergency Department (ED), assessment or inpatient wards.

2.20 Responsiveness to the personal needs of patients.

The data made available to the Trust by NHS Digital with regard to the Trust's responsiveness to the personal needs patients during the reporting period is as follows:

Year	Trust	England Average	England Highest	England Lowest
2015/16	71.7	69.6	86.2	58.9
2016/17	69.5	68.1	85.6	60.0
2017/18	69.6	68.6	85.0	60.5
2018/19	66.5	67.2	85.0	58.9
2019/20	68.0	67.1	84.2	59.5
2020/21	74.3	74.5	85.4	67.3
2021/22	76.0	67.1	84.2	59.5
2022/23	*Following the merger of NHS Digital and NHS England on 1st February 2023 they are reviewing the future presentation of the NHS Outcomes Framework indicators.* *Proposals for changes to the NHS Outcomes Framework were proposed as part of a wide-ranging consultation on statistical outputs that ran from December 2023 to March 2024. The results of this consultation are now in their final stages of approval. Further announcements about this dataset will be made in due course.*			
2023/24				
2024/25				
2025/26				
Data Source: NHS Digital Outcomes Framework NHS Outcomes Framework Indicators, February 2025 release - NHS England Digital				

Whilst the data for the reporting period has not yet been received from NHS Digital, Warrington and Halton Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust considers patients' feedback to be pivotal in ensuring our services continue to develop in order to meet individual patient needs. Please note that in 2020/21, changes were made to the scoring regime, so results are not comparable to previous years.

Warrington and Halton Teaching Hospitals NHS Foundation Trust continue to take the following actions to improve the quality of its services, by undertaking the following actions for improvement:

- Friends and Family Test (FFT) scores are reported through the Patient Experience and Inclusion Sub Committee at Trust wide and Care Group level. The data is also part of the Integrated Performance Dashboard which monitored at the Quality Assurance Committee, Trust Board of Directors and alongside the Integrated Care Board through the Clinical Quality Performance Group.
- In order to ensure that the Trust is responsive to the needs of patients, families and carers learning is taken from incidents, complaints, claims and PALS to consider further service and care improvement.

2.21 Percentage of staff who would recommend the provider to friends or family needing care.

The data is made available to the Trust by the National NHS Staff Survey Coordination Centre on behalf of NHS England with regard to the percentage of staff employed by, or under contract to the Trust during the reporting period. This specifies who would recommend the Trust as a provider of care to their family or friends. NHS England took ownership of the NHS Staff Survey, and the indicator was introduced in April 2014. The latest score for the Trust was 48.3%, when compared with other Acute and Acute & Community Trusts, the average median score was 60.9%. It is recognised that the results may be affected by operational challenges and increased patient attendances throughout the financial year however work continues with system partners to improve the position.

The organisational Culture Plan utilises data from the staff survey as well as other available data to paint a picture of the Trust as a whole, highlighting areas of best practice and opportunities to make improvements, this information is used to target interventions in specific areas of the organisation.

Staff who would recommend the provider to friends or family needing care by percentage*				
Year	**TRUST**	**England Average**	**England Highest**	**England Lowest**
2025	*48.3%*	*60.9%*	88.4%	34.5%
2024	*58.1%*	*61.5%*	89.6%	39.7%
2023	*61.4%*	*63.3%*	88.9%	44.3%
2022*	*55.8%*	*61.9%*	86.4%	39.3%
2021	63.7%	66.9%	89.5%	43.6%
2020	71.3%	74.3%	91.7%	49.7%
2019	65.4%	70.5%	90.5%	39.8%

Staff who would recommend the provider to friends or family needing care by percentage*				
Year	**TRUST**	**England Average**	**England Highest**	**England Lowest**
2018	60.7%	71.2%	90.4%	39.7%
2017	59.5%	70.6%	89.5%	46.4%
Data Source: http: www.nhsstaffsurveys.com/results/ Please note: Figures taken from the Benchmark report are taken from latest available data (2025 survey.) * The precise wording of the question is '*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'.*				

It is also recognised that this report presents the findings of the 2025 national NHS staff survey published on 12th March 2026 which was conducted by Quality Health on behalf of the Trust. Quality Health utilises high quality research methodology and mixed method collection. Results indicate a 38.8% response rate which represents 1812 staff responses.

2.22 Percentage of admitted patients' risk-assessed for Venous Thromboembolism.

The VTE Assessment table below shows performance during the reporting period. Performance is monitored via the Trusts Integrated Performance Report, which is received by the Quality Assurance Committee, Trust Board of Directors and Integrated Care Board.

Reporting Month	% Completion of VTE assessments
01/03/2026	95.26%
01/02/2026	95.52%
01/01/2026	95.12%
01/12/2025	93.30%
01/11/2025	94.61%
01/10/2025	94.25%
01/09/2025	95.47%
01/08/2025	95.47%
01/07/2025	94.03%
01/06/2025	94.94%
01/05/2025	95.06%
01/04/2025	95.09%

Warrington and Halton Teaching Hospitals NHS Foundation Trust have taken the following actions to improve this rate/number, by undertaking the following actions:

- Ward-based teams have been encouraged to utilise real-time data from the Getting it Right First Time (GIRFT) Inpatient Ward Productivity Dashboard to identify and complete outstanding VTE risk assessments.
- Feedback mechanisms have been established with The Clinical Business Units (CBUs) to strengthen understanding of non-compliance, supported by the use of the VTE Risk Assessment Dashboard embedded within monthly CBU Clinical Governance agendas.
- The top 5 wards for non-compliance of VTE risk assessment are made visible in the VTE risk assessment dashboard data to improve their performance data.
- Clinical Leads, Clinical Directors, CBUs and Care Groups are informed monthly of VTE risk assessment performance, enabling targeted actions to improve compliance within their respective clinical areas.

Further improvement actions for VTE RA compliance:

- CBUs will consider working with Ward Managers and Ward Clerks to use real-time data from the Ward Productivity Dashboard to ensure outstanding VTE risk assessments are reviewed and addressed during daily morning board rounds on all working days, with the aim of achieving and sustaining compliance above the mandatory 95% target. Support has been requested from the Corporate Nursing Team.
- A visual guide on " how to drill down the data" on GIRFT ward productivity dashboard has been disseminated to support implementation at ward level through CBU and Clinical Directors.
- In March 2026, a pop-up information box was implemented on the GIRFT inpatient dashboard to clearly signpost and inform users of the underlying data source.
- Positive engagement at ward level has been reported within the Women's and Children's CBU, demonstrating effective local ownership and practice.
- The Patient Safety Nursing Team will reinforce the mandatory contractual requirement to complete VTE risk assessments through the Nursing Forum and via a Trust-wide Safety Brief.
- The Thrombosis Group will continue to monitor VTE risk assessment compliance trends and agree further improvement actions where required.

2.23 Patient Safety Incidents.

The national indicator 'Patient Safety Incidents – Rate of incidents per 1,000 bed days' remains paused while NHS England continues to develop and refine patient safety incident reporting through the Learn from Patient Safety Events (LFPSE) service. As a result, a nationally comparable rate is not currently available for reporting in the 2025/26 Quality Account.

NHS England replaced the National Reporting and Learning System (NRLS) with the Learn from Patient Safety Events (LFPSE) service. During this transition, national publication of some patient safety indicators was paused to ensure data quality, consistency and appropriate interpretation.

The Trust continues to record patient safety incidents locally and nationally via the Learn from Patient Safety Events (LFPSE) service, ensuring that incidents, near misses and learning opportunities are captured and reviewed. The learning and improvements are captured in section 3.12 of this report.

2.24 Friends and Family Test Data.

Following a review undertaken by NHS England, the Lead Official for Statistics has concluded that the characteristics of the Friends and Family Test (FFT) data mean it should not be classed as Official Statistics. Therefore, this is no longer included as a core Quality Indicator.

2.25 Freedom to Speak Up (FTSU)

“We consider Freedom to Speak Up (FTSU) in everything we do, all workers will know how to speak up and feel safe doing it. We will become outstanding by listening and learning from our workforce.”

The FTSU Guardian is a full-time employee so can be flexible in the use of the protected time and provide good cover. The Trust has a named FTSU Executive Lead and Non-Executive Lead. In addition, there are over 50 FTSU Champions from across the Trust representing different backgrounds and professions. Further champions are being recruited to look to further strengthen representation from across the organisation. Workers within the Trust can speak up directly to the Guardian or be sign posted by a Champion; they can text/phone/WhatsApp voice message, email or write to the FTSU Guardian. If details are shared the FTSU Guardian will get in touch with the person raising the issue and offer a face-to-face/teams meeting or the opportunity to discuss further on the phone. The FTSU Guardian will explain the process and advise on what they can do next, the person raising the issue is then supported by FTSU in whatever action they decide to take. FTSU is open to all workers including volunteers, bank and agency workers, students/trainees on placement and contractors working for the Trust.

The Trust has a FTSU Policy which is in line with the national policy stating "If workers raise a genuine concern (i.e., held in reasonable belief) under this policy, workers will not be at risk of suffering any form of detriment or losing their job as a result. Warrington and Halton Teachings Hospitals NHS Foundation Trust will not tolerate the harassment or victimisation of anyone raising a concern. Nor will Warrington and Halton Teachings Hospitals NHS Foundation Trust tolerate any attempt to prevent workers from raising any such concern; in fact, any such attempt would itself raise a concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in further action being taken. Warrington and Halton Teachings Hospitals NHS Foundation Trust hope workers will feel comfortable raising a concern openly, but we also appreciate that workers may want to raise it confidentially, and this will be respected.

The Trust FTSU Guardian completes quarterly national returns on activity and reports to the Trust Board and Strategic people Committee twice a year. The data in the table below shows the number of disclosures raised using the Freedom to Speak Up (FTSU) Guardian and noted reported increase in disclosures year on year.

Table 1 sets out the number of disclosures for the last 3 years and up to Q4 of 2025/26:

Table 1 Number of disclosures

	2022/23	2023/24	2024/25	2025/26
Quarter 1	17	6	15	19
Quarter 2	5	6	15	44
Quarter 3	13	9	36	29
Quarter 4	7	10	21	16
Total	**42**	**31**	**87**	**108**

The types of disclosure cases have been grouped and are detailed in the table below:

Table 2 Themes from disclosures. More than one theme can be reported per case

Reportable themes	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Worker wellbeing	16	28	26	14
Bullying harassment	2	7	2	2
Other inappropriate behaviour	1	0	3	0
Pt Quality	3	13	3	3
Pt Safety	1	4	2	2
Detriment	1	0	0	0
Total	**24**	**52**	**36**	**21**

The number of disclosures is benchmarked against similar Trusts, and national guidance is reviewed and implemented. The Trust conducted a review in 2025 using the national toolkit provided by the office of the national Guardian. The toolkit review is done every two years.

Freedom to Speak Up continues to be socialised throughout the organisation in order to achieve the described objective as making speaking up everyday business.

2.26 Seven Day Hospital Services (7DS).

The Trust is committed to achieving the standards and continues to implement the priority clinical standards for Seven-Day Hospital Services for General Surgery.

NHS England has postponed the 7 Day Service Audit for Acute Medicine. A dashboard covering the 7-day service standards is currently in use and NHS England have released new

standards for the care of acutely admitted patients - NWROC. These supersede the 7-day services standards and are more far reaching. Work has already begun on these in the form of a baseline assessment completed for Acute medicine.

The 7 Day Service Audit remains for General Surgery. The standards are: 'Time to First Consultant Review', in General Surgery. This means that patients should be seen as soon as possible but within at least 14 hours.

General Surgery

This project reviewed emergency general surgical admissions to hospital and the 1st cycle of this audit was completed in July 2021 showing 77% compliance (Admission to Consultant Review within 14 hours). The 2nd cycle audit completed in February 2022 demonstrated 94% compliance (Admission to Consultant Review within 14 hours). A 3rd audit cycle was completed in 2023 showing 72% compliance. A 4th cycle was completed in 2024 showing 93% compliance. A 5th cycle was undertaken in 2025 to assess sustainability in which the details are outlined below:

Data was collected from the Trust patient record system measuring the time of referral to the General Surgery Team to the time of the first documented Consultant review. Patients admitted between 22/09/2025 – 29/09/2025 were included. A total of 37 patients were identified; however, 6 patients were excluded as their diagnosis met our exclusion criteria (Head Injuries or abscesses). Overall, 31 patients were included in the audit.

28 of the 31 patients (93.03%) had a documented Consultant review within 14 hours of admission. The average time to consultant review was 06:34 hours.

The results indicate that the department is once again meeting its target of 90% compliance and that the previous recommendations have been effective in maintaining this. The following recommendations should continue to be implemented to ensure ongoing compliance:

- Ensure that time of consultant review is documented clearly in the patient notes (especially when documenting retrospectively).
- Ensure that consultants are made aware of new admissions so that prompt review can be carried out.
- Ensure that new rotating doctors are made aware of the 14-hour target and these recommendations.

A re-audit has been scheduled to be undertaken in August 2026 to ensure compliance above 90% has been maintained.

2.27 Rota Gaps and Plan for Improvement for NHS Doctors in Training.

NHS Organisations under schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps to be included in a statement in the Trust's Quality Account".

We continue to recruit to doctors in training across our Unplanned and Planned Care Groups.

The table below shows the Deanery Trainee gaps on 4 June 2026:

Deanery Trainee gaps		
Care Group	**Grade**	**Number of Deanery Trainee Vacancies**
Planned Care	GPST Gaps	4.8 WTE Paediatrics
	Specialist Trainee	0.8 ST + X academic trainee (will be spending 6 weeks in research job)
	FY2	1 WTE
		1 x General Surgery
	Trust Grade Doctor	80% WTE Leaving in mid-March – we are in the process of recruiting a new Trust Grade Doctor
Unplanned Care	IMT Gaps	0 (2 in post are 80% LTFT)
	GPST	2 x General Internal Medicine (1 in post is 60% LTFT)
		0 x Acute Internal Medicine (1 in post is 60% LTFT)
	Reg Gaps	0 (7 in post are 80% and 1 in post is 60% LTFT)
	IMY3 Gaps	1 (3 in post are 80% LTFT)
Clinical Support Services	ST4	1 x Radiology

The Trust improvement plan to address rota gaps for NHS Doctors and Dentists in Training is detailed below:

Medical Rota Infrastructure:

- Early identification of gaps from deanery data.
- Implemented of e-rostering for junior doctors.
- General Internal Medicine Resident on call rota generated by grade, within patterns aligning to provide best utilisation of resource

Where Gaps remain, these are mitigated for by the following measures:

- Where gaps occur with short notice, bank and agency junior doctor resource are utilised to maintain safe medical staffing – this remains an option of last choice, with the more sustainable options below being utilised whenever practical.

- Clinical Fellows (CFs) – We continue to recruit to these posts at speciality level, in order to continue to enhance the Multi-Disciplinary Teams at ward level, offering specific experience and research opportunities via fixed term or substantive contracts.

- Trust Grades (TGs) - Recruiting to Trust Grade posts has allowed specialities to provide a senior level doctor in a non-training post within specialities and at ward level. This has enabled us to create additional out of hours support, linked with our General Internal Medicine and surgical specialities rotas.

- Speciality doctors – Recruiting to Speciality Doctors allowed specialities to provide a senior level doctor in a non-training post within specialities and at ward level. Supporting in covering ST3+ gaps within the General Internal Medicine on call rota.

Part 3

Our Quality Improvements and Progress against other Quality Indicators

3.0 Our Quality Improvements and Progress against other Quality Indicators

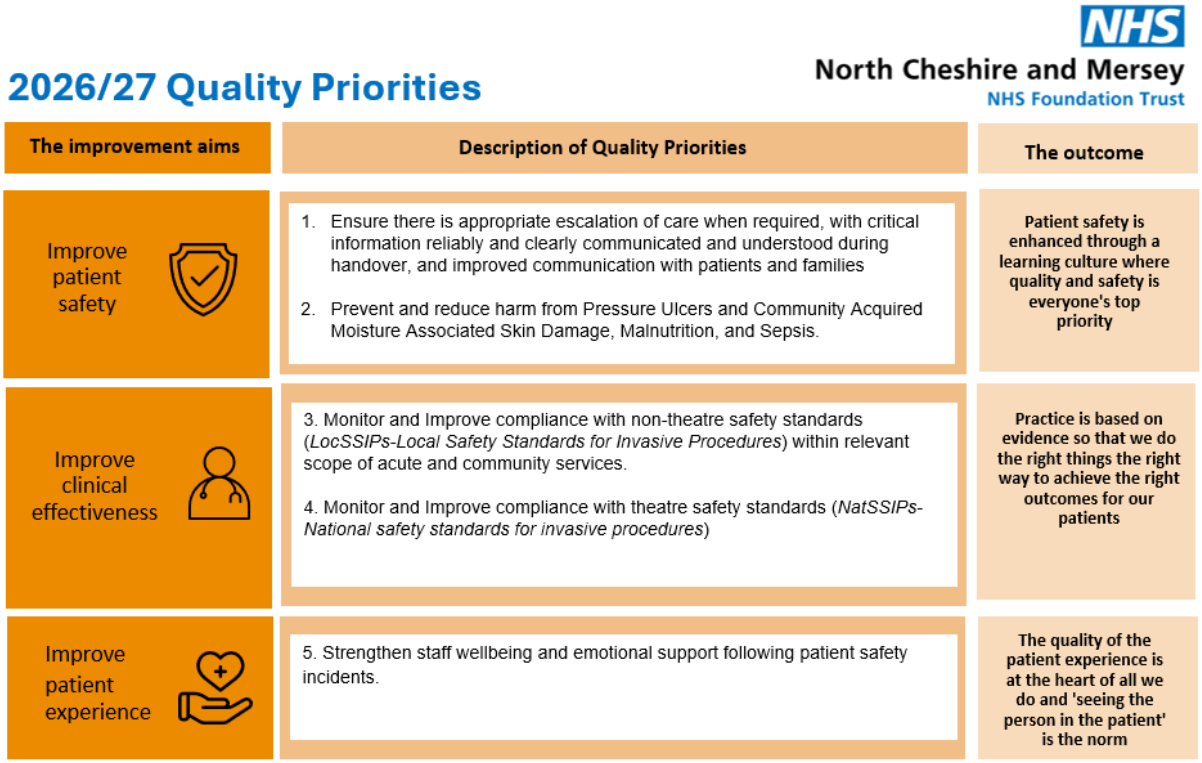
This section details:

- **A summary of the Quality Priorities agreed for 2026/27.**
- **Details on the Trust's performance on a range of other relevant quality performance indicators and thresholds which have been extracted from NHS nationally mandated indicators and locally determined measures.**
- **Detailed information and commentary on a selected range of improvement areas relating to the three domains of quality: Improve Patient Safety, Improve Clinical Effectiveness and Improve Patient Experience.**

Warrington and Halton Hospitals NHS Foundation Trust is committed to maintaining a strong learning culture underpinned by openness, transparency, and robust governance. The Trust's reporting frameworks and oversight structures enable timely identification of issues, drive organisational learning, and support continuous improvement. Through established quality improvement methodologies and a coordinated approach to learning across all functions, the Trust proactively strengthens the quality and safety of care provided to patients.

3.1 Quality Priorities 2026/27.

Our Quality Priorities chosen for 2026/27 align to the three domains of quality with the Trust. These are detailed below:



3.2 Data Sources.

For 2026/27, the Trust has undertaken a robust and systematic approach to identifying its quality improvement priorities. This process draws on a wide range of performance, safety

and benchmarking intelligence to ensure that priorities are both evidence-based and aligned to organisational risk, patient outcomes, and national expectations.

The Trust's assessment incorporated:

- **A full evaluation of progress against the 2025/26 quality and safety priorities**, enabling a clear understanding of achievements, gaps, and areas requiring continued focus.
- **A review of outcomes from the Trust's portfolio of quality improvement projects**, ensuring that learning from completed and current initiatives informs forward planning.
- **Consideration of national and local priorities**, as agreed collaboratively with the Integrated Care Board, ensuring alignment with system-level objectives and population health needs.
- **Assessment against regulatory requirements and Care Quality Commission fundamental standards**, ensuring the Trust continues to meet and exceed statutory expectations.
- **Identification of areas requiring improvement**, based on triangulated intelligence and emerging themes from clinical and operational governance forums.

The Trust utilises a comprehensive suite of intelligence sources to support its analysis. Performance data is submitted to and analysed using NHS Digital datasets, enabling robust external benchmarking and trend identification.

In addition, the Trust maintains strong oversight of patient safety and experience through Datix, its web-based risk management and incident reporting system. Datix provides real-time visibility of incidents, complaints, claims, and Patient Advice and Liaison Service (PALS) enquiries, enabling enhanced triangulation of data to identify risk hotspots and improvement opportunities.

To further strengthen its intelligence capability, the Trust has invested in Healthcare Evaluation Data (HED), a clinically led benchmarking platform that supports detailed comparative analysis of clinical outcomes. This investment enhances the Trust's ability to drive clinical performance improvements and ensure the delivery of high-quality, safe care.

Other key sources of insight include Friends and Family Test data, national inpatient, outpatient and staff surveys, and a range of in-house audit and transparency surveys. These provide valuable qualitative and quantitative feedback and support a holistic understanding of patient and staff experience.

Collectively, these mechanisms provide a high degree of assurance that the 2026/27 quality priorities are well-founded, strategically aligned, and targeted to areas that will deliver the greatest benefit to patients, staff and the wider health system.

3.3 Quality Dashboard.

The clinical indicators in the Quality Dashboard 2024-25 have been reviewed in line with the revised requirements for 2025/26 in relation to the following:

- CQUINs – National (paused at present).
- NHS England KPIs.
- Quality Contract.
- Quality Account - Improvement Priorities.
- Quality Account – Quality Indicators.
- Care Quality Commission.
- Sign up to Safety – national patient safety topics.

- Open and Honest.

This is part of a wider review of quality to align reporting with the committee structure under safety, effectiveness and experience, reporting to the Quality Assurance Committee. The information on this Quality Dashboard is also shared with our Governors and commissioners of services to demonstrate how care for patients is delivered and improvements are maintained.
Since April 2016 the Board of Directors has received an Integrated Performance Dashboard which triangulates quality, access and performance, workforce, and financial information.

3.4 Quality Indicators – rationale for inclusion.

The following section provides an overview of the quality of care offered by the Trust based on performance in 2025-26 against a minimum of 3 indicators for each area of quality namely patient safety: clinical effectiveness and patient experience. These indicators were selected in consultation with stakeholders and discussions with the Quality in Care Committee of the Council of Governors. In the main, the Trust has employed indicators which are deemed to be of local and national importance to the quality of care for patients.

The report provides an explanation of the underlying reason(s) for selection and wherever possible we refer to historical data and benchmarked data if available, to enable readers to understand our progress over time and performance compared to other providers. We have also referenced the data sources for the indicators and if applicable included whether the data is governed by standard national definitions.

Where available comparative and benchmarked data has been included and unless otherwise stated the indicators are not governed by standard national definitions and the source of the data is the Trust's local systems.

The improvement priorities and quality indicators were monitored and recorded via the Quality Dashboard and the Improvement Priority quarterly Report reported to the Quality Committee.

Please note where any of these quality indicators for 2025-26 have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they will not be repeated here; only the additional indicators which have not already been reported in Part 2 will be reported here to avoid duplication of reporting.

3.5 Performance against key national indicators.

The NHS Oversight Framework 2025/26 sets out the national arrangements for assessing NHS providers and determining the level of oversight and support required. The framework is based on a defined set of metrics aligned to national priorities, providing a headline assessment of operational performance, quality and financial sustainability.

NHS England uses a limited set of national measures of access and outcome objectives as part of their assessment of governance at NHS Foundation Trusts.

NHS Foundation Trusts failing to meet at least four of these requirements at any given time or failing the same requirement for at least three quarters will trigger a governance concern, potentially leading to investigation and enforcement action. Except where otherwise stated, any Trust commissioned to provide services will be subject to the relevant governance indicators associated with those services.

Reporting against Core Quality Indicators sets out the relevant indicators and performance thresholds outlined in Appendix A of NHS England's Risk Assessment Framework. Unless stated in the supporting notes, these are monitored on a quarterly basis.

3.6 Performance against the relevant indicators and performance thresholds.

Warrington and Halton aims to meet all national indicators and minimum standards including those set out within the NHS Improvement indicators framework. Performance against the relevant indicators and performance thresholds against national priorities can be accessed via the following link North Cheshire and Mersey NHS Foundation Trust - Board meetings and papers which details the Integrated Performance Report (IPR) and Assurance Committee Reports; which are monitored on a bi-monthly basis at the Public Board of Directors Meetings Part 1.

The Integrated Performance Report includes 76 IPR indicators. The Trust Board of Directors monitors all 76 IPR indicators which have been placed into one of several "Assurance" categories and one of several "Variation" categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count. The Integrated Performance Report and Dashboard has been produced to provide the Trust Board of Directors with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:

- Quality.
- Access and Performance.
- Workforce.
- Finance Sustainability.

The IPR reports can be accessed via the PDF Web Pack which includes Board of Directors papers for each Board of Directors Meeting via the following link: North Cheshire and Mersey NHS Foundation Trust - Board meetings and papers

3.7 National Survey Results.

We utilise national survey results to understand the experience of the people who have received care and treatment from the Trust. The National Surveys presents us with contemporaneous data on the experiences of many patients. It is a rich source of information, but viewed alongside the data we gather from complaints, Friends and Family Test data and local surveys.

The National Survey results help us to ensure we direct our improvement efforts towards actions that will have the greatest impact on patients' experience of care and treatment. While clearly there will be standalone 'quick win' actions to take, equally important are the opportunities to influence our transformation and improvement initiatives by encouraging them to take on Board of Directors insight that the National Inpatient Survey offers us. You can view our latest National Survey results here:

- https://www.cqc.org.uk/provider/RWW/surveys
- Adult Inpatient Survey 2024 (published on 9 September 2025)
- 2024 Urgent and Emergency Care Survey results published November 2024 (Emergency Department)
- Maternity Survey 2025 were published in (10 December 2025)

The CQC have publication dates for their surveys which are listed below and can be accessed here: surveys looking at the experiences of NHS patients.

2024/25 surveys:

- **Maternity Survey 2025:** Published 10 December 2025
- **Adult Inpatient Survey 2024:** Published 9 September 2025
- **Children and Young Peoples Survey 2024:** Published 22 May 2025

3.8 Friends and Family.

The NHS Friends and Family Test (FFT) provides patients, and where appropriate their families or carers on the patient's behalf, with an opportunity to give feedback on the care and treatment they have received at Warrington and Halton Teaching Hospitals NHS Foundation Trust. This feedback is a key mechanism for understanding services from the patient perspective and is used to inform quality improvement and enhance patient experience across the organisation.

The Trust offer digital and paper-based options to complete the FFT survey. This enhances the accessibility and functionality of FFT surveys enabling FFT completion conveniently via responding to SMS messages, scanning QR codes or through the Trust website.

The digital options allow a range of accessibility features, including BrowseAloud functionality to support patients with visual or hearing impairments. Additionally enabling translation into multiple languages and the use of simplified formats, incorporating both text and images to support accessibility for a wider range of users.

Responses include a rating of the patient's experience, which is aggregated and reported to the Board of Directors to support oversight of patient experience and service quality.

Friends and Family Test Scores
Inpatients, Day Cases and Emergency Department

Patients are asked whether they would recommend the service they received, with positive responses used as a key indicator of patient experience. The table below outlines the percentage of positive recommendations, monthly. for the 2025/26 financial year, alongside comparative data for the previous two financial years.

The Trust continues to take a proactive approach to improving both response rates and the quality of feedback received by:

- Listening to and acting upon all sources of patient feedback to inform service improvement
- Identifying opportunities to increase response rates across all areas
- Supporting more real-time data collection to enable responsive improvements

Table One - Friends and Family Test Positive Recommendation Rates

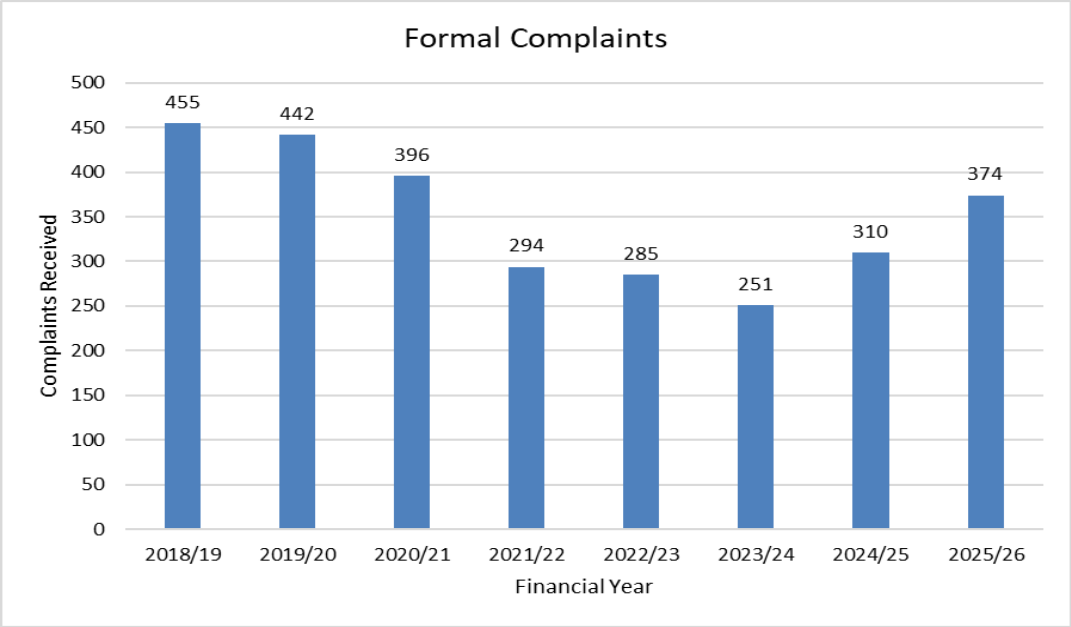
	Inpatients & Day cases			**Emergency Department**		
Month (Financial Year)	**2023/24**	**2024/25**	**2025/26**	**2023/24**	**2024/25**	**2025/26**
April	97%	97%	97%	81%	77%	76%

May	98%	98%	96%	80%	75%	75%
June	98%	96%	97%	72%	78%	70%
July	97%	97%	98%	75%	76%	69%
August	98%	95%	97%	79%	77%	76%
September	96%	96%	96%	78%	78%	70%
October	98%	96%	96%	77%	73%	70%
November	97%	96%	98%	76%	73%	70%
December	97%	98%	97%	73%	72%	73%
January	97%	97%	99%	76%	78%	74%
February	97%	96%	98%	71%	74%	73%
March	98%	97%	96%	75%	74%	71%

Overall, FFT results demonstrate consistently high levels of positive patient experience within inpatient and day case services, with more variable performance within the Emergency Department. The Trust continues to use this feedback to identify areas for targeted improvement and to strengthen patient-centred care across all services.

3.9 Complaints.

The table below details the number of complaints received within the Trust over the year 2025-26. The data demonstrates that the Trust has seen an increase in the number of complaints received from last year with 310 complaints received in 2024-25 compared to 374 complaints received in 2025/26.



The increase in complaints is attributed to pressure on clinical services and increased waiting times for assessment and treatment. It highlights the impact that capacity and resilience challenges have on patient experience, even where care quality remains clinically appropriate.

The Complaints and Concerns Policy has now been ratified aiming that changes in process will allow for an increase in local resolution and timely responses to concerns to ensure effective care for all patients. This in turn is expected to reduce the number of formal complaints received by the Trust.

3.10 Parliamentary and Health Service Ombudsman (PHSO).

The PHSO is a free and independent service. Their role is to investigate complaints where individuals feel that they have been unfairly treated or have received poor service from government departments, other public organisations, and the NHS in England.

Complainants dissatisfied with the Trust's response have the right to ask the PHSO to consider their complaint. However, the complainant must be able to provide reasons for their continued dissatisfaction (in writing) to the PHSO. The Trust may also refer the complainant to the PHSO if they feel that the response has been thoroughly investigated and responded to.

The PHSO will consider the complaint file, medical records, and any other relevant information as necessary. The PHSO may decide not to investigate further, and no further action will be required from the Trust. Alternatively, recommendations might be made for the Trust to consider. The PHSO may decide to conduct a full investigation which might result in the Trust being required to make an apology, pay compensation and/or produce an action plan to describe what actions are planned to rectify the situation and prevent further occurrences.

The table below details the progress of cases received within the Trust over the year 2025-26. In the year 2024/25 the total number of PHSO cases closed was 7, where 3 were upheld, 3 partially upheld and 2 were not upheld. In the year 2025/26, the total number of PHSO cases closed was 4, where 2 were partially upheld and 2 were not upheld with no further action taken following preliminary investigation.

Content	2021/22	2022/23	2023/24	2024/25	2025/26
PHSO cases received	2	3	8	2	2
PHSO cases closed	5	6	2	7	4
Ongoing PHSO Cases at the end of 2024-25 = 5 Cases					

Content	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
PHSO cases received	0	0	0	0	1	0	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0
PHSO cases closed	1	1	0	0	2	1	0	1	0	0	1	0	0	0	1	0	1	0	0	1	0	0	1	0
Ongoing PHSO Cases at the end of 2024-25= 5 Cases																								

3.11 Patient Stories

Patient, family and carer experiences are central to how we design, review and improve our services. Feedback captured through lived experience and patient stories provides meaningful insight into what matters most to those who use our services. This enables us to better understand individual needs and drive improvements across both hospital and community settings.

Patient stories are routinely shared across a range of governance committees and meetings and are embedded within staff training programmes. This supports colleagues to develop a deeper understanding of patient perspectives, informs service redesign and highlights examples of good practice that can be shared more widely to support organisational learning.

Stories presented to the Trust Board are also published within the public Board of Directors' meeting papers (Part 1), ensuring transparency and accountability. These can be accessed via the North Chesire and Mersey NHS Foundation Trust website.

As a result of this feedback, a number of improvements have been implemented, including:

Improving support and communication in the Emergency Department

- Introduction of trial information screens within the Emergency Department waiting area to support Accessible Information Standards, improve communication and manage expectations
- Installation of call bells for patients receiving corridor care to enhance safety and accessibility
- Implementation of structured waiting room observations to better monitor patient wellbeing
- Modified approaches to support patients with Learning Disabilities and Autism
- Delivery of trauma-informed care training for colleagues to improve patient experience
- Development of a volunteer recruitment programme to enhance patient support

Supporting patients with reasonable adjustments

- In collaboration with Healthwatch Warrington, trialling the "About Me" card to support patients who have experienced trauma, alongside utilising patient identifiers on records
- Introduction of pre-admission visits to help reduce anxiety and support familiarisation with the environment
- Development of an outpatient reasonable adjustments pivot table, enabling proactive contact with patients to identify and plan required support
- Provision of extended and flexible appointment times for patients requiring additional communication or support needs

These initiatives demonstrate how patient, family and carer feedback directly informs service development, helping to ensure care is more responsive, inclusive and person-centred.

3.12 Patient Safety Incidents.

Learning and Improving Patient Safety

Patient safety incidents are any unintended or unexpected events which could have, or did, lead to harm for people receiving care. Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) promotes an open and transparent reporting culture and views high levels of reporting, particularly of no-harm and low-harm incidents, as an indicator of a positive safety culture. Reporting incidents provides valuable opportunities to learn, prevent recurrence and improve the quality and safety of services.

All incidents are reported through the Trust's Risk Management System and are uploaded to the NHS Learn from Patient Safety Events (LFPSE) service to support local and national learning.

Patient Safety Incident Response Framework (PSIRF)

WHH adopted the Patient Safety Incident Response Framework (PSIRF) on 1 September 2023, in line with national requirements for organisations providing NHS-funded care. PSIRF focuses on learning and improvement, rather than attribution of blame, and promotes proportionate, systems-based responses to patient safety incidents.

The Trust's Patient Safety Incident Response Policy and Plan is available on the Trust website and intranet. Oversight of PSIRF is provided through established Trust governance arrangements. The PSIRF Executive Review Group considers all patient safety intelligence and shared learning as part of PSIRF to support its ongoing implementation across the Trust, including high level assurance briefings from the Executive-led Safety Oversight Meeting.

The PSIRF Executive Review Group ensures that the four main aims of PSIRF are implemented and embedded across North Cheshire and Mersey NHS Foundation Trust:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approached to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening system learning and quality improvement

Identification of Learning

WHH has a robust process in place to monitor incidents ensuring that learning is identified to support improvements. This includes:

- Patient Safety and Clinical Effectiveness Sub Committee.
- Quality Assurance Committee.
- Integrated Performance Report (reports through to Trust Board of Directors).
- Clinical Business Unit Governance Meetings.
- Care Group Governance Meetings.
- Executive Led Weekly Safety Oversight Meeting.
- The PSIRF Executive Review Group
- Executive weekly dashboard.
- A quarterly 'Learning from Experience' report is discussed at the Quality Assurance Committee and contains both quantitative and qualitative data analysis, triangulated to demonstrate learning from Incidents, Complaints, Claims, Health and Safety, Clinical Audit, Inquests, Quality Improvement and Research, Compliance and Patient Experience.

There is shared analysis, learning and improvement identified from clinical incidents across the Trust via the following routes:

- Quarterly Governance Reports, including the Learning from Experience Report and Learning from Deaths Report. This is reviewed at the Quality Assurance Committee.
- Incident, Complaints, Claims and Inquest overview which is reviewed bi-monthly at the Patient Safety and Clinical effectiveness Sub Committee.
- Trust wide safety alerts and notifications.

- Safety briefings in clinical areas.
- Amendments to policy.
- Learning events throughout the year.
- Daily Safety Huddles.
- Trust wide Safety brief.
- Monthly CBU and Specialty Governance Meetings.

Learning response methods

In line with PSIRF, WHH uses a range of learning response methods, selected according to the nature and potential learning /impact of each incident. These include:

Multidisciplinary Team (MDT) reviews

Open discussions that bring together different professional perspectives to identify contributory factors and system gaps affecting safe patient care.

Swarm huddles

Rapid, on-site MDT discussions held as soon as possible after an event to understand what happened and agree immediate actions to minimise future risk.

After Action Reviews (AARs)

Facilitated, structured discussions based on four key questions to identify learning and improvement actions.

These methodologies support a proportionate and compassionate response to safety events and enable learning at individual, team and organisational levels.

Involvement of patients, families and staff

WHH is committed to compassionate engagement with patients, families, carers and staff following patient safety incidents. Where appropriate, patients and families are involved directly in learning responses, supported by dedicated liaison officers. This approach ensures that learning is informed by lived experience and that patients and families receive timely information, support and feedback.

Two Patient Safety Partners are in post and contribute to embedding PSIRF across the Trust.

Local PSIRF priorities

The Trust reviews its incident profile regularly to identify themes and priorities for deeper learning. The three local priorities are:

- Missed or delayed diagnosis of cancer
- Delays in the identification, recognition and response to patient deterioration, resulting in delayed escalation and treatment
- Delays in risk assessment and/or management of patients with underlying mental health concerns, leading to delayed treatment

Learning from these investigations informs Trust-wide improvement activity and quality priorities.

Building capability and expertise

The Trust continues to invest in developing patient safety capability and leadership. Training aligned to the national Patient Safety Training Syllabus is available to staff via the Electronic Staff Record, with high levels of compliance across staff groups. In addition, Patient Safety Specialist training has been completed by a cohort of staff, with further training planned to strengthen investigative, oversight and engagement capabilities.

WHH has taken the following actions to improve the quality of services by:

- Incident data being instantaneously uploaded to the LFPSE service.
- Continue to undertake patient safety investigations in line with the Patient Safety Incident Response Policy and Plan.
- Continue to improve how we understand patterns in patient safety incidents and complaints, helping us focus on the issues that matter most to patients.
- Continue to engage meaningfully with our patients, families, and carers to ensure that their voice is included in patient safety investigations
- Continue to enhance how we check that we are being open and honest with patients and families when something goes wrong, including better systems to monitor this.
- Continue to enhance training for staff to use the Trust's Risk Management System, incident module within Datix.
- Continue training in line with PSIRF Training Needs Analysis
- Continue to monitor actions for improvement consistently, tracking via internal governance processes, ensuring they are completed in a timely manner.
- Additional scrutiny continues at the Trust's Executive Led Safety Oversight Group, chaired by the Chief Nurse. The members monitor and scrutinise incidents where harm has been caused or any other incidents that may potentially indicate a potential risk to patient safety and have scope for learning.

3.13 Duty of Candour.

The Trust is committed to being open, honest and transparent with patients and families when something goes wrong with care. This is known as the Duty of Candour.

The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015 in line with the Health and Social Care Act 2012. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. Requirements include informing people about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

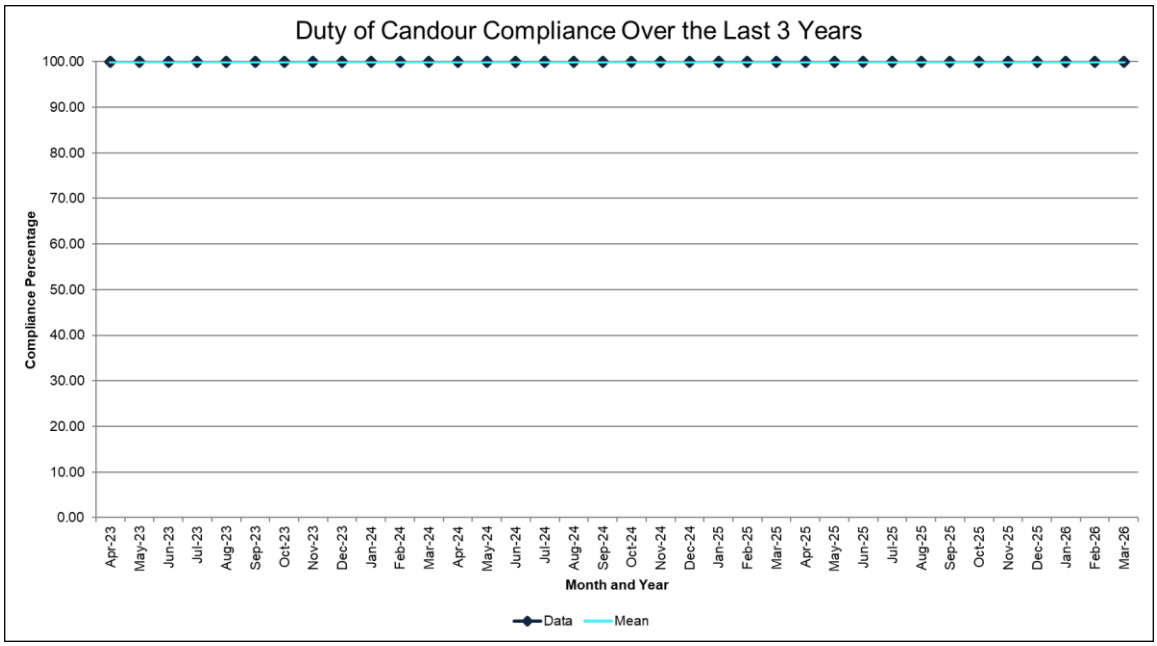
Statutory Duty of Candour is a legal duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England. All registered providers must demonstrate that they are meeting regulatory requirements to register with CQC and then continue to deliver regulated services. CQC Regulation 20: Duty of Candour, requires that "as soon as reasonably practical after becoming aware of a notifiable safety incident (moderate, severe, prolonged psychological harm for at least a continuous period of 28 days and death) the health service body must:

- Notify the service user/someone lawfully acting on their behalf (the “relevant person”) that the event has occurred.
- Provide “reasonable support” to the relevant person.

The Trust monitors Duty of Candour at the weekly Executive Led Safety Oversight Meeting, chaired by the Chief Nurse. Duty of Candour continues to be reported to the Patient Safety & Clinical Effectiveness Sub-Committee. The Trust has a stand-alone Duty of Candour Policy to support staff with the delivery of Duty of Candour.

In 2025/26, there were 173 incidents reported where Duty of Candour was applied. The Trust continues to achieve 100% compliance. This is a key focus for each Care Group and the associated Clinical Business Units, ensuring that early high-quality conversations with patients and families take place.

Duty of Candour (by incident reported date)					
Financial Year	**FQ1**	**FQ2**	**FQ3**	**FQ4**	**Grand Total**
2020 – 2021	10	27	16	47	100
2021 – 2022	26	32	29	46	133
2022 – 2023	33	47	32	51	163
2023 – 2024	39	26	23	21	109
2024 – 2025	16	25	28	33	102
2025 – 2026	25	69	50	29	173
Grand Total	149	226	178	227	780



3.14 Compliance for Patient Safety Alerts.

Patient Safety Alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients. These alerts are issued by NHS England through the Central Alerting

System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations.

Patient safety alerts are developed with input, advice and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, Royal Colleges and other professional and national bodies. The panel discuss and advise on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the National Reporting and Learning System (NRLS) (now replaced by (Learning From Patient Safety Events) LFPSE) and Strategic Executive Information System by NHS Trusts and other health care providers and also from concerns raised by members of the public. Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider programme of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

Coordination of patient safety alerts is carried out by the Health and Safety Team who work with various Trust departments and CBUs to facilitate compliance and monitor on-going work or action plans used to address the issues raised.

All of the alerts that Warrington and Halton Teaching Hospitals, NHS Foundation Trust receive are detailed on the CAS email system, as all alerts are not recorded through the CAS web site since 2019 (CHT/2019/001) and 2020 (CHT/2020/002) and 2021 (CH/2021/001 + 002).

To support information (alerts) received, a spreadsheet is maintained where information about each alert is recorded, and evidence of implementation and actions taken to ensure compliance is recorded in Datix. The following tables provide information on the alerts received by each month and financial year.

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019-20	6	7	7	11	3	7	21	16	14	12	21	15	140
2020-21	20	14	10	14	11	13	6	11	14	5	15	9	142
2021-22	6	4	10	7	8	9	7	15	13	8	16	9	112
2022-23	6	13	6	6	6	5	9	14	5	8	6	10	94
2023-24	4	8	2	9	9	8	2	3	9	5	8	5	72
2024-25	8	8	7	11	9	6	13	7	7	5	4	9	94
2025-26	7	5	9	11	6	3	4	7	5	8	6	9	80
Grand Total	**57**	**59**	**51**	**69**	**52**	**51**	**62**	**73**	**67**	**51**	**76**	**66**	**734**

National Patient Safety Alerts Financial Year / Month													
Type of Alert	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**

2021-22	0	1	3	1	3	0	0	1	0	0	0	2	11
2022-23	1	1	1	0	2	0	1	2	0	2	1	0	11
2023-24	0	3	1	2	1	2	0	1	3	2	2	0	17
2024-25	2	3	0	2	0	1	2	0	1	0	0	1	12
2025-26	0	0	1	2	0	1	0	1	2	2	0	0	9
Grand Total	**3**	**8**	**6**	**7**	**6**	**4**	**3**	**5**	**6**	**6**	**3**	**3**	**60**

1. The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information to the NHS and others, including dependant providers of health and social care.

2. Trust policy: *Central Alerting System (CAS)* Policy, sets out how received alerts will be processed through the Trust, administration for dealing with safety alerts it through the Trust's nominated CAS Liaison Officer (CASLO) who is responsible for cascading alerts to the relevant groups and individuals (a role associated with the Health and Safety Department).

3. Distribution and closing of alerts are overseen by the Head of Health and Safety, and monitoring of compliance is undertaken through the Health and Safety Subcommittee, with the Chief Nurse identified as the Executive Lead.

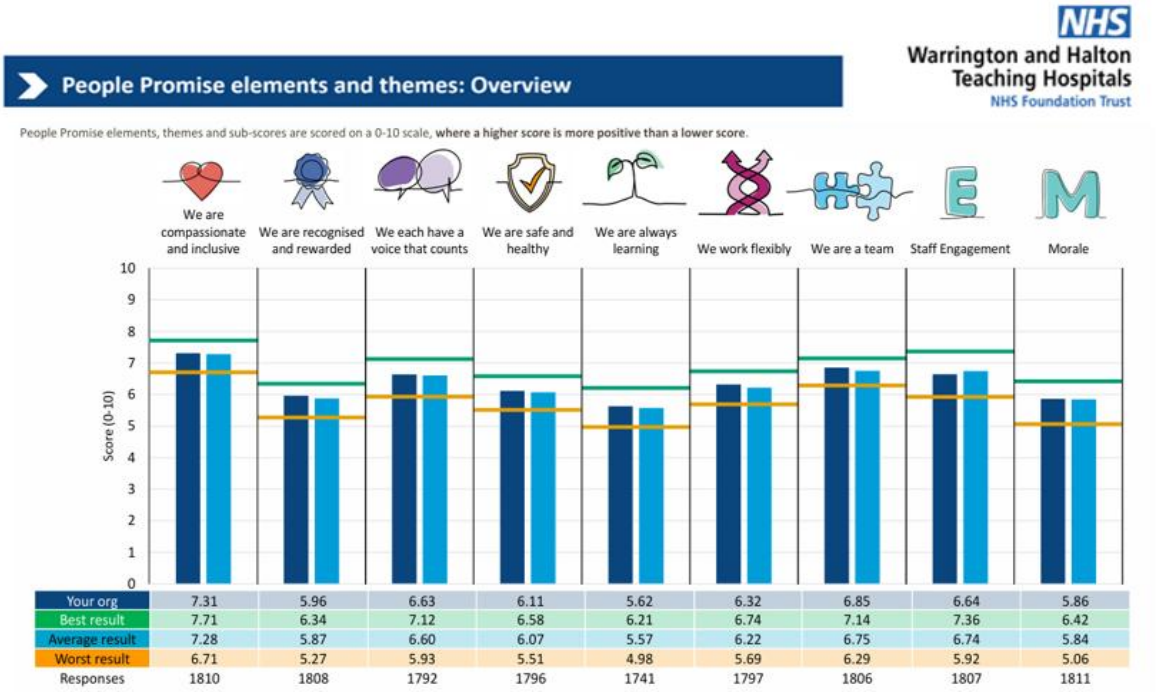
4. Where necessary for an alert such as a National Patient Safety Alert (NatPSA), as required distribution will also include an Executive Lead with oversight of the project related to the needs of the alert, to completion of all actions and closure to the Central Alerting System (CAS) website.

3.15 Staff Survey Results.

All NHS Trusts are required to survey their workforce annually using the National Staff Survey. The survey comprises around 100 questions. The NHS England benchmark reports are themed in line with the nine elements of the survey, including the NHS People Promise and two themes of 'Staff engagement' and 'Morale'.

People Promises and Themes in the 2025 Staff Survey	
People Promise (PP) / Theme (T)	**Sub-score / Theme**
We are compassionate and inclusive (PP)	• Compassionate culture • Compassionate leadership • Diversity and equality • Inclusion
We are recognised and rewarded (PP)	• Not applicable
We each have a voice that counts (PP)	• Autonomy and control • Raising concerns

We are safe and healthy (PP)	• Health and safety climate • Burnout • Negative experiences
We are always learning (PP)	• Development • Appraisals
We work flexibly (PP)	• Support for work-life balance • Flexible working
We are a team (PP)	• Team working • Line management
Staff engagement (T)	• Motivation • Involvement • Advocacy
Morale (T)	• Thinking about leaving • Work pressure. • Stressors (Health and Safety Executive Index)
Data Source: NHS People Plan – published 2023: www.england.nhs.uk/ournhspeople/	



The most updated results from the 2025 NHS Staff Opinion Survey results for the themes of "We are Compassionate and Inclusive" and "We are Safe and Healthy" are as follows:

We are compassionate and inclusive

WHH scored 7.31 for this theme overall which is higher than comparator organisations of 7.28 but is 0.11 lower than the Trusts 2024 score of 7.42. For question 15 "Does your organisation act fairly with regards to career progression/promotion, regardless of age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation" the Trust scored 56.34% compared to the Acute Trust average of 53.05%. The Trust is above

the national acute Trust average, however, recognises the importance of ensuring equity in relation to progression and promotion.

The Trust has a Workforce Equality, Diversity and Inclusion Strategy (2022-2025), which has an annual refresh of workplans, and priorities based on the staff survey intelligence. In addition, the We are WHH: Culture Plan, utilises the survey data as a metric for targeting support in the right services across the Trust.

Additionally, there are specific action plans in place aligned to the Workforce Race Equality Standard and the Workforce Disability Equality Standard to continue to improve the experience of our workforce in relation to acting fairly in terms of career progression or promotion irrespective of protected characteristic. This is reported through our Strategic People Committee on a bi-annual basis to ensure monitoring of improvements and that actions meet targeted deadlines. More information about this can be found on the Trust website.

Aligned to the introduction of the NHS Equality, Diversity and Inclusion Improvement Plan in June 2023, further work will be completed based on the results of the 2025 survey to ensure that disparities experienced by certain protected characteristics are addressed.

We are Safe and Healthy

The Trust scored 6.11 for this theme which is higher than the comparator score of 6.07.

In relation to harassment, bullying or abuse at work:

- Question 14b asks “How many times have you personally experienced harassment, bullying or abuse at work from managers?” The Trust scored 8.18% which is a deterioration from the 2024 score of 7.62% and lower than the comparator Trust score of 9.20%.
- Question 14c asks “In the past 12 months how many times have you personally experienced bullying, harassment, or abuse at work from other colleagues?” The Trust scored 15.97% which is an improvement from the 2024 score of 16.35% but remains lower than the national median at 17.86%.

There remains further work to do in this area focused on the disparities experienced by certain protected characteristics. This is monitored through the Workforce Inclusion and Culture Sub-Committee, chaired by the Chief People Officer.

The organisational Programme of kindness, civility and respect continues which has been integrated with the Patient Safety Incident Response Framework (PSIRF) program of work to effect organisational cultural change. In addition, this intelligence feeds into the We are WHH: Culture Plan which focuses on ensuring that everyone has “a good day at work”.

3.16 Healthcare Associated Infections.

A summary of mandatory reportable healthcare associated infections (HCAI), cases for 2025/26, compared to previous years, is included in the table below.

The numbers include hospital onset/healthcare associated and community onset/healthcare associated cases apportioned to the Trust.

Table * Mandatory Reportable Healthcare Associated Infections (HCAI)

	Trust Apportioned Cases 2022-23	Trust Apportioned Cases 2023-24	Trust Apportioned Cases 2024-25	Trust Apportioned Cases 2025-26
Meticillin-Resistant Staphylococcus aureus (MRSA) bacteraemia	3	0	4*	0
Meticillin-Sensitive Staphylococcus aureus bacteraemia (MSSA) *	21	36	34	35
C. difficile	55	55	90	81
E. Coli Bacteraemia	67	81	89	82
Klebsiella Spp. Bacteraemia	23	28	30	27
P. aeruginosa Bacteraemia	4	11	10	10

* 1 MRSA bacteraemia case re-apportioned to another healthcare provider following Integrated Care Board review

There is a robust system for data entry and validation which ensures that all mandatory reportable infections (listed above) are entered onto the UK Health Security Agency (UKHSA) data capture system in line with mandatory reporting requirements.

HCAI are monitored monthly on the Integrated Performance Report (IPR) and information forwarded to the Infection Control Sub-Committee, Quality Assurance Committee, Trust Board of Directors and the Cheshire and Merseyside Integrated Care Board (ICB).

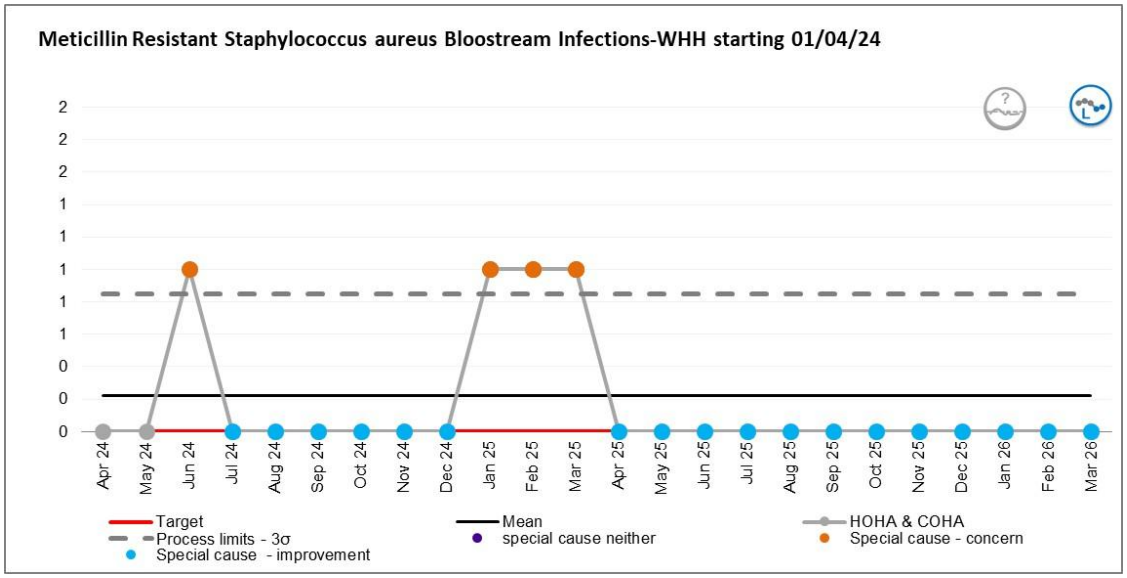
***Meticillin-resistant Staphylococcus aureus* (MRSA) bacteraemia**

There is a zero-tolerance approach to avoidable MRSA bacteraemia cases.

Nil Trust apportioned MRSA bacteraemia cases were reported.

This was a decrease by 3 cases compared to the previous year and met the zero-case ambition.

Graph 1 shows the results for MRSA bacteraemia cases from Apr 24 to Mar 26.



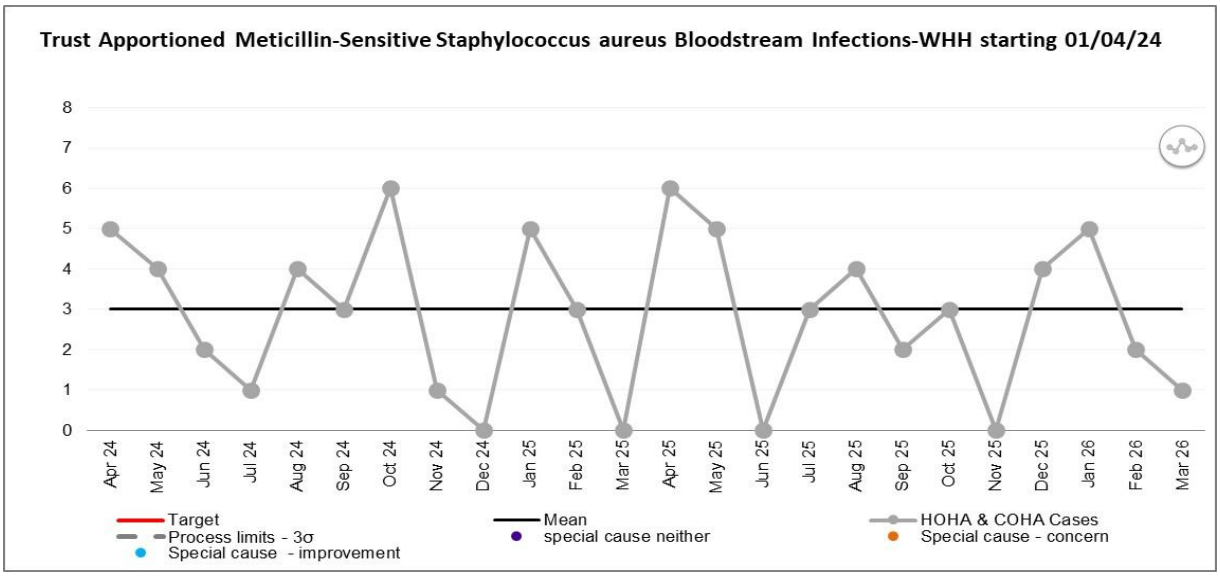
***Meticillin-sensitive Staphylococcus aureus* (MSSA) bacteraemia**

There is no set threshold for MSSA bacteraemia cases.

35 Trust apportioned MSSA bacteraemia cases were reported.

This was an increase by 1 case compared to the previous FY.

Graph 2 shows the results for MSSA bacteraemia cases from Apr 24 to Mar 26.



Some of the MSSA bacteraemia cases were associated with deep seated infections that could not be prevented. An action plan is in place to reduce preventable MRSA/MSSA bacteraemia cases. This focuses on compliance with MRSA admission screening, education on use of aseptic non-touch technique, auditing practice standards for care of invasive devices and sharing learning from incidents.

Clostridioides (Clostridium) difficile (*C. difficile*)

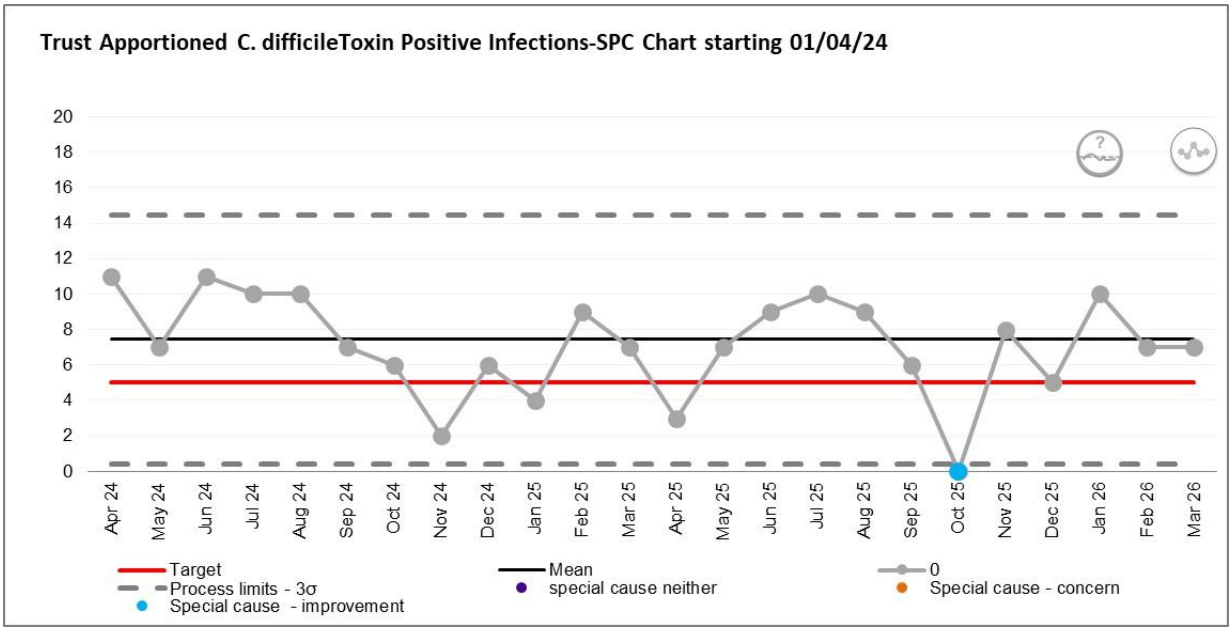
The threshold for *C. difficile* was 60 cases.

81 Trust apportioned *C. difficile* cases were reported.

This is a decrease by 9 cases compared to the previous year.

According to UKHSA, the Trust remains a low outlier for *C. difficile* compared to other northwest Trusts.

Graph 3 shows the results for *C. difficile* cases from Apr 24 to Mar 26.



There is an action plan in place to prevent *C. difficile* cases which focuses on antimicrobial stewardship, environmental hygiene, hand hygiene, surveillance to detect case clusters and compliance with the SIGHT mnemonic (suspect, isolate, gloves and aprons, handwashing and toxin testing).

Gram-negative Bloodstream Infections (GNBSI)

Within the National Action Plan on confronting antimicrobial resistance (2024/29), an aim was set to prevent any increase in Gram-negative bloodstream infections (GNBSI) from the 2019/20 financial year baseline.

Partnership working is in place across the health economy to progress action plans to prevent GNBSI.

A breakdown of Trust performance for each mandatory reportable GNBSI is detailed below.

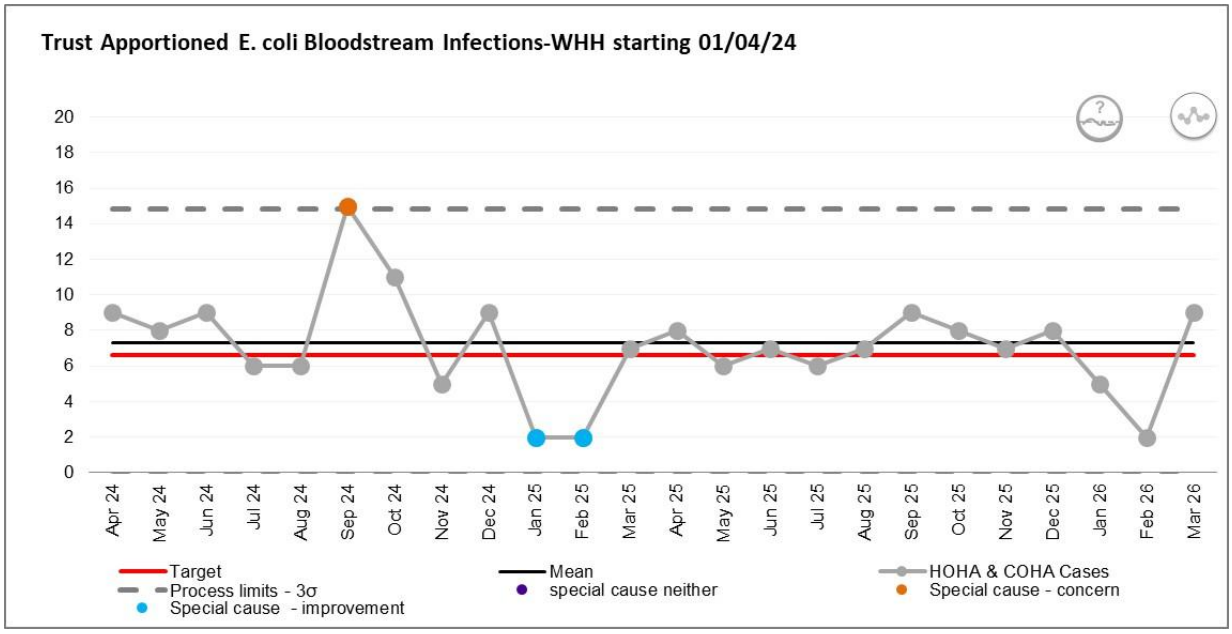
***E. coli* Bacteraemia.**

The threshold for *E. Coli* bacteraemia cases was 79 cases.

82 Trust apportioned cases were reported.

This is a decrease by 7 Trust apportioned cases compared to the previous year.

Graph 4 shows the results for E Coli Bacteraemia cases from Apr 24 to Mar 26.



***Klebsiella spp.* Bacteraemia.**

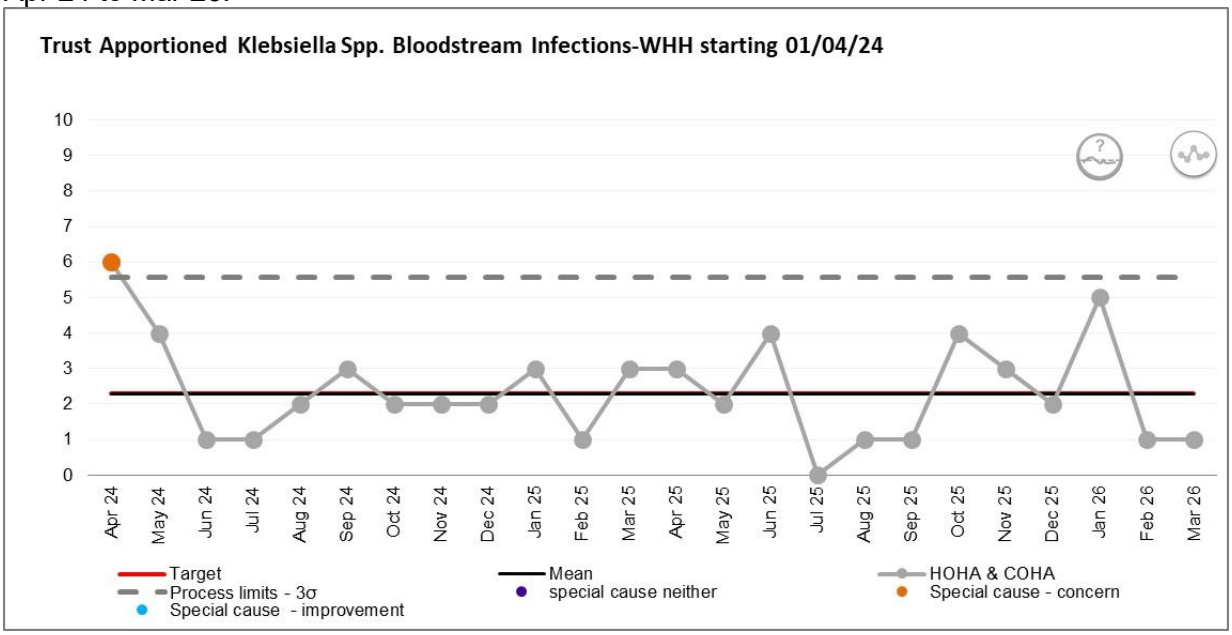
The Threshold for *Klebsiella spp.* Bacteraemia was 28 cases.

27 Trust apportioned cases were reported.

This is a decrease by 3 Trust apportioned cases compared to the previous year.

The Trust remained under the annual threshold by 1 case.

Graph 5 shows the results for Trust Apportioned Klebsiella spp. Bacteraemia Cases from Apr 24 to Mar 26.



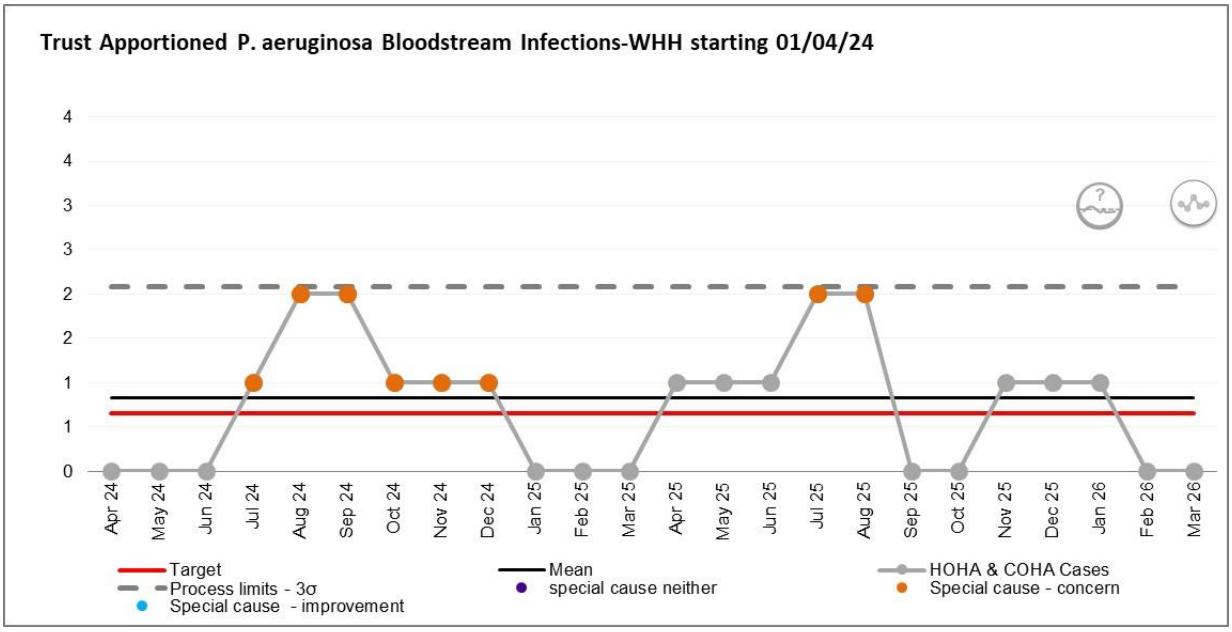
***P. aeruginosa* Bacteraemia.**

The threshold for *P. aeruginosa* bacteraemia was 8 cases.

10 Trust apportioned cases were reported.

Cases numbers remain unchanged from the previous FY.

Graph 6 shows the results for Trust Apportioned P. aeruginosa bacteraemia cases from Apr 24 to Mar 26.



How progress will be monitored, measured and reported

- Mandatory reporting to UKHSA
- Continuous monitoring of Trust apportioned HCAIs and patient outcomes
- Review and updates to action plans to prevent: -
    - Methicillin resistant *Staphylococcus aureus* (MRSA) and Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia cases
    - *C. difficile* cases
    - Gram-negative bloodstream infections (GNBSI)

- Focus on best practice and learning from investigation of mandatory reportable HCAI aligned to the Patient Safety Incident Response Framework and Safety Engineering in Patient Systems (SEIPS) framework
- Infection Prevention and Control Sub Committee monthly
- Patient Safety and Clinical Effectiveness Sub-committee monthly
- Quarterly Director of Infection Prevention and Control Report presented to the Quality Assurance Committee showing in year progress

The Trust will continue to work with system partners to improve infection prevention and control practice and reduce HCAI. The integration with community healthcare providers provides an opportunity to strengthen system learning.

Actions will be directed to ensure ongoing compliance with the Code of Practice on prevention of Healthcare Associated Infections and the Board of Directors Assurance Framework.

3.17 Quality Academy Overview.

The Quality Academy (QA) was established in 2018 as a vibrant centre of inquiry, bringing together our Clinical Audit, Continuous Quality Improvement, Knowledge and Evidence Services and Research, Development and Innovation teams. The Quality Academy promotes innovation and improvement and is part of an enabling arm to deliver the Trust Quality Priorities.

Objectives

WHH Key priorities for the Quality Academy are:

- To support the delivery of the Quality Priorities.
- Work collaboratively with other services across the Trust to embed and sustain continuous improvements.
- Develop a learning culture of continuous quality improvement within the Trust.
- Develop training programs including training in Quality Improvement Methodology and other QA work streams.
- Support to move toward best practice with use of Data and Evidence Services.
- Support Programmes of work, alongside system partners to sustain and optimise clinical improvements.

3.17.1 Quality Academy: Continuous Quality Improvement (CQI).

The Continuous Quality Improvement (CQI) Team aims to improve quality of care and staff experience through the application of QI methodologies. The drivers that have underpinned this aim this financial year are:

1. Supporting organisational priority and high impact improvement projects
2. Building QI Capability, Capacity and Culture
3. Supporting Better Care Together Integration

3.17.1.1 Supporting organisational priority and high impact improvement projects

The central CQI Team works collaboratively with clinical, operational and transformation team colleagues to support the delivery of strategic improvement priorities. In the past year, this has included:

Harm Free Care QI Collaborative focussing on Pressure Ulcers and MUST compliance

Pressure ulcers are the single most costly chronic wound in the NHS, costing around £3.8 million per day in England alone (NHS Improvement, 2018). Pressure ulcers have a significant impact on patients, their care givers and their families. They cause pain and discomfort, increase the risk of infection and overall, reduce quality of life. They can also lead to longer inpatient stays, increased healthcare costs and higher mortality rates. The CQI Team has facilitated a series of workshops and learning sessions with ward teams to to understand the challenges staff experience in preventing pressure ulcers and undertaking MUST screening, to test out approaches to improvement in practice and to support sharing of learning across teams. In the first 3 quarters of this year, we have achieved a 14% and 18% improvement in compliance with MUST screening within 24 hours and 7 days respectively, compared to 2024-25. For the period March 2025-February 2026 WHH achieved an 11.8% reduction in pressure ulcers compared to the previous 12 months.

Theatres Productivity Improvements

At Warrington and Halton Hospitals, 70.6% of elective theatre sessions start late* (data from April to August 2024). This contributes to poor theatre utilisation, with associated financial implications and leads to on the day cancellations and long waiting lists where a patient's condition may deteriorate, impacting on their quality of life and creating a poor patient experience. Following previous work to understand the root causes of late starts using methods such as process mapping, time and motion study, waste analysis, the CQI Team continued to support the development and implementation of several tests of change including changes to the process to transfer patient from the ward to theatre, implementation of a forward wait area, visual management to support patient readiness for theatre on the ward, and a pre-admission telephone checklist. A sustained reduction in late starts has been achieved over the past 12 months, although further improvements are required for efficient use of theatre capacity.

In addition, the CQI Team worked with key stakeholders to map the processes for booking patients for surgery, with a focus on pre-operative assessment, to understand current practice and identify inefficiencies, to inform the redesign of pre-op pathways.

Reducing ward length of stay (LOS)

Average length of stay on one of the general medicine wards over the 15 months to June 2025 was 12.42 days. This has been increasing year on year and is higher than the national average of 10.8 days for general medicine emergency admissions (Model Health System Data Feb 2025). Extended hospital stays can lead to increased risk of hospital-acquired infections, patient deconditioning, and delayed access for new patients requiring admissions resulting in pressure on ED and other parts of the system. The CQI Team facilitated a 3-day Rapid Process Improvement Workshop with good attendance and engagement from the ward team and positive feedback from staff involved. Incorporating a combination of training in QI/lean methods and practical application, we completed a thorough problem analysis identifying opportunities for reducing length of stay and facilitating earlier discharge where appropriate.

Reducing DNAs in Gastroenterology

Approximately 12% of patients did not attend their Gastroenterology appointment in the year 2024-25. This equated to 864 appointments. This is higher than the Trust average of 8% over the same period. Missed appointments are costly, resulting in wasted clinical time, additional administrative burden to reschedule appointments and contributing to longer waiting times for other patients. Missed appointments can impact patient health outcomes, delay diagnosis or disrupt treatment plans and lead to worsening symptoms, disease progression and potentially, more intensive, costly treatment and hospital attendances. The CQI team, together with the Knowledge and Evidence Service, have supported the service team to understand and map existing booking processes, analyse data to identify any patterns and trends, and obtain patient feedback to understand the reasons for DNAs from a patient perspective, to inform the development of improvement initiatives, including for example, two new standard operating procedures and development of new pathways for Patient Initiated Follow Up.

Reducing inappropriate referrals for inpatient echocardiogram

The CQI and Transformation Teams having been working with the Cardiorespiratory Team, resident doctors and consultant cardiologists to reduce inappropriate inpatient echo referrals. The project has been focussed on improving awareness of inpatient echo guidelines, alongside streamlining internal processes to make it easier to appropriately refer for inpatient testing. Implementation of defined triaging criteria in line with the British Society of Echocardiography (BSE) guidelines supports more effective prioritisation, with shorter triage times, reduction in diagnostic delays, and timely assessment for patients who most urgently require echocardiography. Earlier identification of cardiac concerns enables faster initiation of appropriate treatment plans, shortens inpatient waiting times, and ultimately helps improve clinical outcomes and overall patient experience.

3.17.1.2 Building QI Capability, Capacity and Culture

Progress against NHS IMPACT Five Components for Continuous Improvement systematic approach

In early 2024, we developed a driver diagram aligned to the five components of NHS England's NHS IMPACT (Improving Patient Care Together), outlining the key activities we need to deliver to build and sustain and culture of continuous improvement across the organisation and aligning with CQC well-led requirements. Table 1 provides a high-level

overview of progress against these drivers. These updates have been discussed and reviewed in a variety of committee meetings and with relevant leads since WHH submitted our NHS Impact self-assessment in 2023.

Table 1
Progress against CQI Driver Diagram aligned to NHS Impact Components and relevant CQC Well-led elements:

Aim	Primary Drivers	Secondary Drivers	Actions completed or underway
To build and embed a culture of learning and systematic continuous improvement approach at WHH	Building a shared purpose and vision (CQC Well-led: Shared direction and culture; Partnerships and communities)	Ensure our people understand the Trust vision, strategy and organisational priorities and improvement work is aligned to this	Increased QI involvement in annual planning process. Increased attention towards QI coaching around strategic priorities at project initiation meetings.
		Develop a robust Quality Strategy and implementation plan with specific outcomes metrics	Quality Strategy 2025-27 developed and launched. Metrics/measures are linked with the annual quality priorities (QP) work plans and monitored via separate QP meetings.
		Improve governance, oversight, accountability and monitoring within care groups and CBUs to ensure improvement efforts are aligned to priorities	Improved oversight through monitoring via governance meetings, supported by development of a QI dashboard on LION. However, issues remain with receiving updates on progress of projects and levels of discontinued projects. A new escalation process for overdue projects is currently being trialled, alongside allocated QI leads for care groups.
		Harness opportunities for collaboration, connection and shared learning across ICB improvement programmes	Active involvement in Cheshire and Merseyside Improvement Network.
		Collaborative working and alignment between Quality Academy and Governance, People Directorate, Operations & Transformation, Strategy & Partnerships, Learning & Organisational Development, Patient Experience, Patient Safety Improvement Nurses and Communications teams	Close working with transformation team on Delivery Unit programmes, series of workshops held to facilitate further development of team's relationships and delineated roles.
		Support national improvement initiatives and QI programmes	QI support provided to Martha's rule implementation and focused QI work linked with annual quality priorities.

		Increase collaboration with patients, service users and family/carers, e.g. through involvement Experts by Experience, to ensure all CQI work focusses on what matters	Incorporated in QI training. Requests for Expert by Experience and patient involvement in majority of projects supported by the QI team but co-production is not embedded as standard.
	Investing in people and culture (CQC Well-led: Workforce equality, diversity and inclusion)	Regular assessment of culture and organisational readiness for continuous improvement and link with staff surveys	Launch of organisational culture programme linked with NHS Impact framework
		Create conditions that support and encourage staff to find time and space to lead and participate in improvements, for example, building CQI as part of business as usual, e.g., staff huddles on QI progress, governance meetings, job descriptions, job plans, appraisals, etc.	Staff frequently report challenges finding time to complete QI work, evidenced in the high proportion of registered projects that are discontinued. Increasingly, attendance at and demand for QI training is reducing due to capacity constraints.
		Recognise, share and celebrate improvement work and learning through planned events and other means e.g. Quality Academy Showcase, shared learning forum, internal and external award nominations, QI work publications, poster presentations for national, regional and local conferences, etc	Limited resource to continue supporting events that previously facilitated sharing and celebrating success and learning. Quality Academy Showcase cancelled for 2025; Shared Learning Forum reduced from quarterly to biannual. Quality Improvement Practitioner Community paused due to poor uptake and limited capacity to support.
		Develop of a quality improvement community/network/forum to encourage sharing of learning and peer support	Quality Improvement Practitioner Community (QIPC) paused due to poor uptake and limited resource to support.
	Developing leadership behaviours (CQC well-led: Capable, compassionate and inclusive leaders; Learning, improvement and innovation)	Board development sessions to ensure Board and executive leadership aligned to CQI methodology and Quality Management System development programme	Making Data Count Training was completed by the Board in March 2025.
		Visible senior leadership, sponsorship of QI projects, modelling of CQI behaviours and attendance at celebration and learning events	Regular attendance of executive leaders at excellence events and Trust wide learning forum has been challenged due to focus on integration and financial position. Oversight and engagement at QASC and DUP meetings. Annual QA Showcase was not held this year due to re-prioritisation of resources due to prioritising productivity and integration.
		Clear lines of accountability and governance of CQI work	SROs identified for strategic priority projects. Sponsorship and escalation routes not always

			clear for small scale projects and CQI work progress to be monitored in governance meetings.
		Development of a coaching style of leadership, encouraging autonomy and ownership of improvement, ideas generation; consistent application of QI methodology where appropriate, including the use of measurement over time.	Greater emphasis on use of data over time in decision making
		Embedding learning system as part of continuous improvement principles, including learning from failure from iterative changes and learning from excellence.	Learning Framework has been agreed in PSIRF ERG; but still needs to establish agreed structure and process through the upcoming planned Sustained Learning Group before it is embedded across the Trust.
	Building improvement capability and capacity (CQC Well-led: Learning, improvement and innovation)	Ensure a clear and consistent improvement methodology and common language is communicated and utilised across the Trust	Embedding of the WHH Five Essentials of Continuous Quality Improvement, alongside a range of resources, including toolkit, quick reference guide, certification criteria, SOP, etc. All QI training aligned to Five Essential approach. However, continued lack of clarity on the distinction and appropriateness of different approaches to change e.g. transformation/project management vs. QI vs audit. This needs revisiting in the integration delivery programme.
		Develop and deliver an extended training offer, in collaboration with partner organisations, tailored to individual staff needs, for example, Corporate Induction, Preceptorship QI Foundation, QI Practitioner, Coach, Leadership for Improvement, Doctors in Training, Bitesize modules, Masterclasses etc	Continued delivery of Corporate Induction, QI foundation and QI practitioner training. Recently developed e-learning Introduction to QI. Level 4 QI coach programme and Level 5 Leadership for Improvement programmes not progressed
		Recruit, develop and support QI coaches throughout the organisation	Investment in 5 coaches to complete NHS Elect train the trainer programme. Roll out of in-house training paused due to capacity constraints
		Identify and harness staff with existing untapped improvement skills to support strategic priority continuous improvement goals	CQI team works collaboratively with transformation team on productivity improvement programmes. Annual business planning process to streamline with alignment of QI and transformation resourcing and annual quality priorities setting.

	Embedding improvement in management systems and processes (CQC Well-led: Governance, management and sustainability; Learning, improvement and innovation)	Develop a consistent, coordinated and sustainable approach to managing quality across the organisation from quality planning to quality assurance, incorporating continuous improvement, innovation and learning, knowledge mobilisation	Quality Academy inputs are incorporated in annual business planning processes. Greater incorporation of Knowledge and Evidence to support decision making.
		Embed QI within the CQC readiness programme and PSIRF programmes, ensuring triangulation of learning from regulatory and governance processes and sharing of best practice	QI and other team members from Quality Academy supported previous CQC mock inspection and ward accreditation programmes. This needs revisiting of the CQC SAF programme of work notably in well-led domain where Quality Academy scope is mostly involved with.
		Support the adoption of Making Data Count across the organisation to monitor quality, recognise early warning signals, and highlight significant improvement or deterioration, supporting better decision making and prioritisation of resources	Guideline for understanding and interpreting SPC charts developed together with Senior Performance and Systems Development Lead. A series of training sessions delivered to WHH and BCHT teams to support Making Data Count.

Building Improvement Capability and Capacity – Training Delivery and Evaluation

The CQI Team continue to deliver a programme of internal training to support Trust staff to gain the knowledge and skills required to deliver QI projects in their own areas. Our Level 2 Foundation and Level 3 Practitioner Training have successfully achieved re-accreditation by the RCN this year. Figure 3 below outlines the number of staff who have completed Level 2 and 3 training.

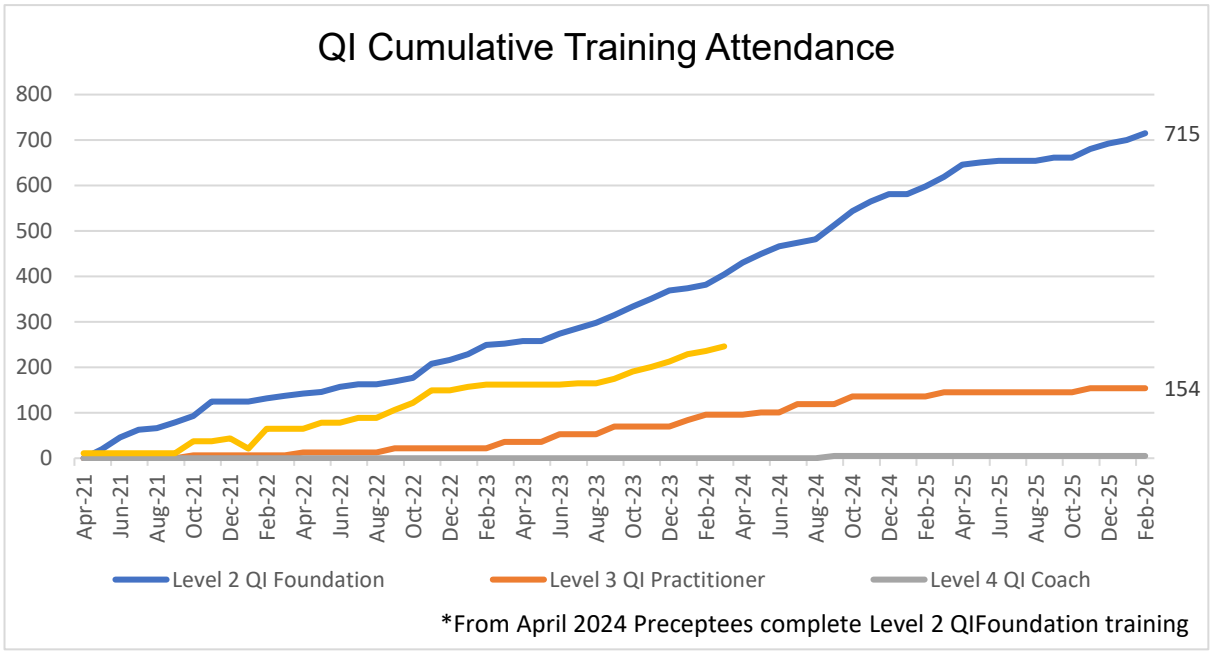


Figure 1 The number of staff trained over time in the QI Foundation, Practitioner and Preceptorship Programme.

We collect and review feedback following each training session delivered to ensure that we continuously learn and improve the training we provide to ensure we meet the needs and expectations of participants to deliver QI work. The average quality score (on a scale of 0-10) for Level 2 Foundation and Level 3 Practitioner course for 2025-26 YTD is currently 8.9 and 9.4 out of 10 respectively. To measure the impact of Level 3 QI Practitioner training, we ask participants on a scale of 1 – 10 how confident they were to lead a QI project, both before and after the training. Figure 4 demonstrates the significant increase in confidence on completion of the training across cohorts.

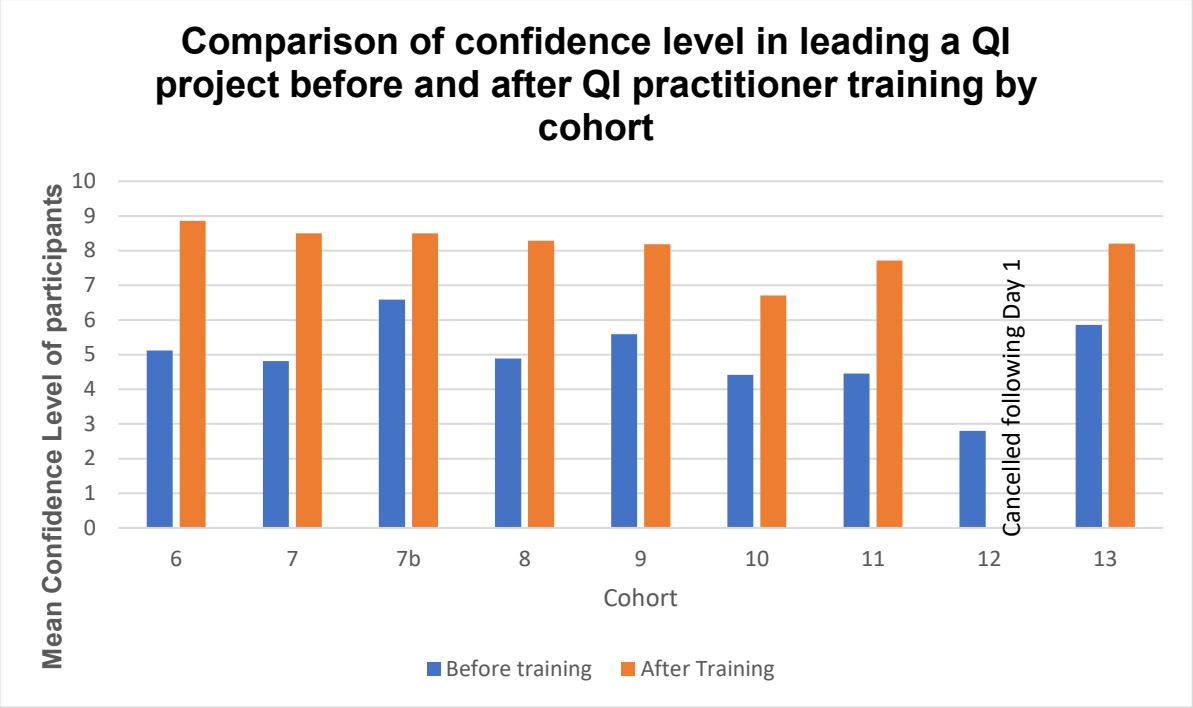


Figure 2 Comparison of confidence level in leading a QI project before and after QI practitioner training.

Local Quality Improvement Projects (QIPs)

Teams across the Trust are encouraged to develop their own QIPs to make improvements in their local areas. We continue to refine and improve our internal processes to support the use of robust QI methodology throughout the organisation and drive sustained improvement.
Local QI initiatives and projects that have been completed have highlighted the following achievements over the course of the financial year:

- Reduction in the average number of hospital/A&E attendances for patients with severe asthma by 44% following the introduction of a dedicated paediatric severe asthma clinic at Warrington Hospital
- Sustained compliance with ensuring women who are at high risk of Foetal Growth Restriction have a uterine artery doppler scan, as required within the Saving Babies' Lives care bundle.
- Significantly improved completion rates for care processes for paediatric diabetes patients - Overall health check completion rates for the over 12yrs age group increased from 65% to 94.5%. Urine (Albumin-to-Creatinine Ratio) ACR completion improved from 69.6% to 95.9%. And eye screening completion improved significantly from 68% to 93%.
- Improved average time in therapeutic range (TTR) for hospitalised patients on warfarin – TTR doubled from 39.6% to greater than 80%. Increasing TTR reduces the risk of complications such as stroke.
- Improved screening and onward referral for social isolation amongst patients presenting to the Frailty Assessment Unit - increase in screening from 1% at baseline to 81% and an average of 6 referrals per month to local support services.
- Reduction in inappropriate referrals for abdominal x-ray from 21% to 7%

- Improved compliance with fit testing of FFP3 respirator masks - a 54% improvement was achieved with compliance reaching 74%.
- Significantly improved safeguarding processes across Warrington and partner agencies through implementation of a multi-agency Standard Operating Procedure (SOP) for Child Protection Medicals (CPMs). Prior to this intervention, 79% of CPMs completed under Section 47 enquiries did not comply with guidance, resulting in inappropriate hospital attendances, prolonged admissions, delayed investigations, and unnecessary trauma for children and families
- Improved risk assessment and documentation processes within Pulmonary Rehabilitation group exercises programmes to ensure safety and maximise treatment outcomes

Building and sustaining a culture of continuous improvement

Making Data Count – Guideline and training

Understanding and using data effectively is essential to improving the quality of care we provide. Statistical Process Control (SPC) is a powerful tool that helps us make sense of variation in our processes and make informed decisions. They help to distinguish signal (something worth investigating) from noise (normal variation). This year, together with the Senior Performance and Systems Development Lead, we developed a Guideline for understanding and interpreting SPC charts to standardise how we use SPC charts across the organisation and delivered a series of aligned training sessions to support teams to make their data count.

Quality Improvement Dashboard

To help improve oversight and governance of local quality improvement work, we have developed a Quality Improvement dashboard. This enables Care Groups and CBUs to access up to date information at any time, including the number of staff who have completed QI training and details of registered QI projects in each area.

Shared Learning Forum (SLF)

To further develop a culture of learning and improvement, a Shared Learning Forum (SLF) was launched in February 2024 with an aim to provide an opportunity for WHH colleagues, partners, and people with lived experience of our services to share, learn and engage in interactive activities. This year we held two North Cheshire and Mersey HealthCare Partnership Shared Learning Forums in May and November 2025, sharing learning on the following topics:
Theme: Learning from Communication and Engagement (patients and staff)

- Learning from Experts by Experience engagement: Website redevelopment project
- Learning from Staff Engagement: Flexible working
- Learning from Maternity Services: Improvement work with patients' voice
- Learning from Staff Recognition initiative: 'Feel Good Friday' initiative from BCHT

Theme: Learning from Excellence and Embracing Change.

- Starting with Parents: Improving Smoking Cessation Practice in Paediatrics

- Improving the Coagulation Control of Hospitalized Patients on Warfarin
- Improving health literacy
- Learning from patient safety: Patient safety incident investigation (PSII) thematic reviews
- Best Start for Life: Embracing Change, Parent Infant mental health

3.19.1 Supporting Better Care Together Integration

We have started to work with colleagues at Bridgewater to understand the commonalities and differences in methodologies and approaches used for improvement and change, and to review resources together to identify what could be shared/adapted across organisations. Some examples of this include:

- Delivery of two Joint shared learning forums
- Joint delivery of four virtual training sessions on Making Data Count with the Bridgewater Information team
- Extension of QI training offers to Bridgewater Community colleagues

Annexes

Annex 1: Quality Account Statements

Statements from Integrated Care Board of Directors (ICBs), Local Healthwatch Organisations and Local Overview and Scrutiny Committees and other stakeholders 2025/26 are presented within this document unedited by the Trust and are produced verbatim.

Integrated Care Board have assumed responsibilities for the review and scrutiny of Quality Accounts and will now be requested to provide a statement on the Quality Accounts. (Integrated Care Board of Directors (ICBs) replaced Clinical Commissioning Groups (CCGs) in the NHS in England from 1 July 2022).

NHS England clarifies that Foundation Trusts are only required by regulation to share their Quality Report with NHS England or relevant ICBs (as determined by the NHS (Quality Accounts) Amendment Regulations 2012), local Healthwatch Organisations and Overview and Local Scrutiny Committees.

The NHS Cheshire and Merseyside Integrated Care Board have assumed responsibilities for the review and scrutiny of Quality Accounts, and to key stakeholders as part of the regulatory requirement and consultation process and feedback is noted within the ICB letter including:

- Integrated Care Board (ICB)
- Healthwatch
- Overview and Scrutiny Committee

There is no regulatory requirement for Foundation Trusts to share their Quality Account/Report with Health and Wellbeing Board.

Statement from the NHS Cheshire and Merseyside Integrated Care Board (ICB) on the Quality Account

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Cheshire and Merseyside

Ref: Warrington and Halton Teaching Hospitals NHS Foundation Trust

NHS Cheshire and Merseyside ICB
No1. Lakeside
920 Centre Park Square
Warrington
WA1 1QY

29th May 2026

Sent by email to:
Alison Kennah, Chief Nurse
alison.kennah@nhs.net

Re: 2025/26 Quality Account Statement

Dear Alison

NHS Cheshire and Merseyside Integrated Care Board welcomes the opportunity to review and comment on the Warrington and Halton Teaching Hospitals NHS Foundation Trust Quality Account for 2025/26.

NHS Cheshire and Merseyside recognise the strong progress made by the Trust in achieving six of its nine quality priorities for 2025/26, with a further two priorities partially achieved. Notable successes include improvements in the timely assessment of patients within urgent and emergency care, reflecting the effective embedding of new systems and the introduction of additional 'hot clinics' to support discharge and avoid unnecessary admissions. Additionally, there have been improvements in patient flow, a reduction in 'did not attend' rates, and the adoption of a whole-system approach to strengthening theatre safety culture.

We will continue to work collaboratively with the Trust to support the implementation of the remaining areas for improvement, with a particular focus on enhancing the experience and care of patients with learning disabilities and impaired mental health - areas where current provision does not yet meet the Trust's ambitions. We are supportive of the improvement framework and governance arrangements that are in place, and we will maintain close engagement with the Trust throughout 2026/27 to ensure sustained progress and delivery of these priorities.

NHS Cheshire and Merseyside would like to acknowledge the progress made across patient safety, clinical effectiveness and patient experience. It is positive to see continued focus on safety, including strong compliance with Duty of Candour and established approaches to learning from incidents. The sustained high levels of VTE risk assessment compliance are encouraging, however continued focus on sustainability and the effective implementation of improvement actions will ensure this performance is consistently maintained going forward.

Developments to clinical pathways and services are positive. The introduction of the Colorectal Nursing Triage Team is a strong example of service improvement, helping to streamline pathways, support earlier diagnosis and improve patient experience. The investment in diagnostic services with the use of AI and initiatives to improve patient flow, such as the Older Persons Short Stay Unit, demonstrates a clear commitment to improving access, timeliness and outcomes.

The Trust's audit and research programmes have been described within the account and assure oversight of clinical effectiveness. The findings described around dementia, bedside

transfusion practice and paediatric diabetes are positive, we will work closely with the Trust to understand more about the clinical audit findings requiring action during 2026/27 and support this delivery to allow further improvement journeys to be presented in the next quality account.

The Trust's open learning culture is clearly demonstrated within the Account, with particular emphasis on learning from mortality reviews. NHS Cheshire and Merseyside welcome the identification of key themes and shared learning.

The priorities for 2026/27 show an appropriate focus on safety, effectiveness and patient experience. The use of a range of data sources and feedback to inform these priorities is positive, and the continued focus on integration with community services is an important area of development. The priorities in relation to surgical safety are a positive continuation of work undertaking during 2025/26 to tackle learning from Never Events, this continued focus will seek to ensure consistent safety during invasive procedures.

In conclusion, the Quality Account reflects continued progress and a clear commitment to improvement. We would like to thank the Trust's staff, leaders and partners for their continued dedication and engagement throughout the year. We look forward to continuing to work with the Trust as it delivers its priorities for the year ahead.

Yours sincerely

Fiona Lemmens
Executive Clinical Director
NHS Cheshire and Merseyside ICB

cc.Kerry Lloyd, Josette Niyokindi

NHS Cheshire and Merseyside
No 1 Lakeside, 920 Centre Park Square
Warrington, WA1 1QY

Communications@cheshireandmerseyside.nhs.uk
Cheshireandmerseyside.nhs.uk

Statement from the Trust's Council of Governors on the Quality Account

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Account for 2025/26.

The Quality Account is comprehensive and informative, providing Governors with valuable insight into the quality of services delivered by the Trust. It supports the Council of Governors in its role of holding the Non-Executive Directors to account for the performance of the Board of Directors and provides assurance regarding the quality, safety, and effectiveness of patient care.

A key responsibility of Governors is to maintain a focus on quality. As part of the Trust's governance arrangements, Governors meet regularly with the Chair and Non-Executive Directors and receive performance information that enable them to scrutinise performance, seek assurance, and raise questions where appropriate. Governors also observe Board committees, including the Quality Assurance Committee. Following each meeting, the appointed Governor Observer reports to the Council of Governors on the effectiveness of the Committee Chair, including their ability to provide constructive challenge and obtain assurance regarding the quality of services provided.

Formal meetings of the Council of Governors are held in public and are open to members of the community to observe. Governors also participate in a range of subcommittees and working groups, including the Patient Experience and Inclusion Subcommittee, which provides an important opportunity to represent the views and experiences of members, patients, carers, and the wider community.

The Governors strongly support the Trust's continued focus on patient safety, clinical effectiveness, and patient experience, which are clearly reflected throughout this Quality Account.

As the Trust prepares to transition to the North Cheshire and Merseyside NHS Foundation Trust during 2026/27, Governors support the quality priorities identified for the coming year. These priorities build on learning from 2025/26 and have been informed by national and local priorities, performance data, and stakeholder engagement. Governors have received presentations and updates throughout the development of these priorities and are supportive of the proposed areas of focus.

The Patient Safety Priorities relating to:

1. Ensure there is appropriate escalation of care when required, with critical information reliably and clearly communicated and understood during handover and improved communication with patients and families.
2. Prevent and reduce harm from Pressure Ulcers and Community Acquired Moisture Associated Skin Damage, Malnutrition and Sepsis.

Clinical Effectiveness Priorities regarding:

3. Monitor and improve compliance with non-theatre safety standards (LocSSIPs-Local Safety Standard for Invasive Procedures) within relevant scope of acute and community services.
4. Monitor and improve compliance with theatre safety standards (NatSSIPS-National Safety Standards for Invasive Procedures).

The Patient Experience Priorities relating to:

5. Strengthen staff wellbeing and emotional support following patient safety incidents.

Governors are assured that the 2025/26 Quality Account presents information that is meaningful, accessible, and transparent. The report provides clear evidence of performance, demonstrates trends over time, and enables comparison with previous years.

The format and structure of the report are helpful and reflect the breadth and complexity of services provided by the Trust. Governors believe the Quality Account presents an accurate and balanced view of performance and clearly demonstrates the progress made in improving patient safety, clinical outcomes, and patient experience.

The Council of Governors encourages Trust members, patients, carers, staff, and members of the public with an interest in local healthcare services to read the Quality Account and learn more about the Trust's achievements and priorities for the future.

Sue Fitzpatrick
Lead Governor
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Joint statement from Healthwatch Halton and Healthwatch Warrington on the Quality Account

1.Does the draft Quality Account reflect people's real experiences?

Overall, the Quality Account reflects a broad range of patient experiences, supported by multiple feedback mechanisms including Friends and Family Test results, national surveys, patient stories and complaints data. High recommendation rates for inpatient care (96–99%) demonstrate generally positive experience, although Emergency Department scores remain lower, highlighting areas for improvement. The increase in complaints (374 in 2025/26) is acknowledged transparently and linked to service pressures and waiting times. The inclusion of patient stories and 'Experts by Experience' demonstrates commitment to using lived experience to shape services.

2. Is there evidence that basic things are not being done well?

The Quality Account is open about areas where performance does not yet meet expectations. Examples include inconsistent compliance with sepsis treatment standards, documentation gaps for patients with learning disabilities, delays in Emergency Department assessment times, and workforce limitations affecting tobacco dependency support. Complaint increases and lower ED patient experience scores also indicate challenges in access and timeliness.

These issues suggest that while fundamental care is largely delivered safely, consistency and reliability across all areas remain areas for improvement.

3. **Is there a clear learning culture?**

Yes, the Quality Account demonstrates a strong and developing learning culture. This is evident through the implementation of the Patient Safety Incident Response Framework (PSIRF), high levels of incident reporting, and structured approaches such as After-Action Reviews, swarm huddles and multidisciplinary reviews. Learning is triangulated from incidents, complaints, claims and audits, and shared through quarterly 'Learning from Experience' reports. The Trust also invests in staff training (e.g. quality improvement, health literacy, MECC) and embeds continuous improvement through its Quality Academy and governance structures.

4. **Are priorities for improvement challenging and measurable?**

The priorities for improvement are aligned to the three domains of quality (patient safety, clinical effectiveness and patient experience) and are supported by clearly defined metrics, such as waiting times, compliance percentages and outcome measures. Performance against previous priorities is reported transparently, including where targets have not been met (e.g. pressure ulcer reduction and sepsis compliance). Future priorities build on internal data, national standards and stakeholder engagement. While some targets are ambitious and appropriate, ensuring consistent delivery and measurable improvement across all services will be key.

I would also like to add that we believe that WHH staff and leadership team work very well as a partner and work tirelessly to be open and transparent regarding patient feedback with Healthwatch. WHH are working in exceptionally challenging times.

Lydia Hughes
Joint CEO for Healthwatch Warrington and Healthwatch Halton

Statement from Warrington Overview and Scrutiny Committee on the Quality Account

Noted within the ICB statement letter following presentation with all key stakeholders.

Statement from Warrington Health and Wellbeing Committee on the Quality Accounts

Noted within the ICB statement letter following presentation with all key stakeholders.

Statement from the Halton Health Policy Performance Board of Directors on the Quality Accounts

Noted within the ICB statement letter following presentation with all key stakeholders.

Annex 2: Statement of directors' responsibilities for the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

The Trust Board Directors are responsible for the preparation and publication of the Trust's Quality Account in accordance with the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 (as amended), and relevant guidance issued by NHS England.

In preparing the Quality Account, the Directors have taken steps to satisfy themselves that:

- The Quality Account meets the requirements set out in the Quality Accounts Regulations and applicable NHS England guidance.
- The content of the Quality Account is not inconsistent with internal and external sources of information, including:
    - Board of Directors' minutes and papers for the period 1 April 2025 to 31 March 2026;
    - Reports and papers relating to quality presented to the Board of Directors during that period.
    - Feedback received from Cheshire and Merseyside Integrated Care Board dated 29 May 2026.
    - Feedback received from the Council of Governors dated 11 June 2026.
    - Feedback received from local Healthwatch organisations (Healthwatch Halton and Healthwatch Warrington) dated 15 June 2026.
    - Feedback received from the Overview and Scrutiny Committee dated 29 May 2026.
    - Feedback received from Halton Borough Council dated 29 May 2026.
    - The 2025 NHS Staff Survey published on 12 March 2026.

- The Quality Account presents a fair, balanced and understandable assessment of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- Appropriate internal controls are in place over the collection and reporting of quality performance information, and these controls are subject to review to confirm that they operate effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to defined data quality standards and prescribed definitions, and is subject to appropriate scrutiny and challenge.

The Directors confirm that, to the best of their knowledge and belief, the Quality Account has been prepared in accordance with statutory requirements and presents a true and balanced view of the Trust's quality performance for the period covered.

By order of the Board of Directors

Nikhil Khashu
Chief Executive

Andy Carter
Chair

Annex 3: Independent Auditor's Assurance Report on the Annual Quality Report

The Quality Accounts are no longer required to undergo an independent review, and NHS providers are not expected to obtain assurance from external auditors on their Quality Account.

The accounts will continue to be shared with key Stakeholders for external scrutiny and comment.

Annex 4: Glossary of Abbreviation and Definitions

Abbreviations	Definitions
A&E	Accident and Emergency.
AMU	Acute Medical Unit.
API	Associate Principal Investigator scheme providing in-work research training opportunities.
AWaRe	Access, Watch and Reserve classification used to guide appropriate antibiotic use and antimicrobial stewardship.
BCH	Bridgewater Community Healthcare NHS Foundation Trust.
CBU	Clinical Business Unit responsible for operational and clinical delivery within the Trust.
CDI	*Clostridioides (Clostridium) difficile* infection.
Clinical Audit	A quality improvement process that measures care against explicit standards and uses findings to improve patient outcomes.
COHA	Community-Onset Healthcare-Associated infection.
CQC	Care Quality Commission, the independent regulator of health and care services in England.
CQI	Continuous Quality Improvement, an approach that supports ongoing improvement in care and services.
CQUIN	Commissioning for Quality and Innovation payment framework.
DNA	Did Not Attend.
DSPT	Data Security and Protection Toolkit used to assess NHS information governance and cyber security compliance.
Duty of Candour	A statutory requirement for healthcare providers to be open and transparent with patients and families when a notifiable patient safety incident occurs.
ED	Emergency Department.
EPR	Electronic Patient Record.
ESR	Electronic Staff Record.
FFT	Friends and Family Test, a national patient feedback tool.
FTSU	Freedom to Speak Up, supporting staff to raise concerns safely.
GAU	Gynaecology Assessment Unit.
GIRFT	Getting It Right First-Time national improvement programme.
GP	General Practitioner.

Abbreviations	Definitions
HCA	Health Care Assistant.
HES	Hospital Episode Statistics, a national dataset of hospital activity.
HOHA	Hospital-Onset Healthcare-Associated infection.
HQIP	Healthcare Quality Improvement Partnership.
ICB	Integrated Care Board.
ICNARC	Intensive Care National Audit and Research Centre.
IPC	Infection Prevention and Control.
IPR	Integrated Performance Report used for Trust assurance and monitoring.
ISMS	Information Security Management System.
IVOS	Intravenous to Oral Switch of antimicrobial therapy.
Learning from Deaths	A national NHS framework to identify, review, investigate and learn from patient deaths.
LFPSE	Learn from Patient Safety Events service, replacing the NRLS.
LocSSIP	Local Safety Standards for Invasive Procedures.
MDT	Multi-Disciplinary Team.
MECC	Make Every Contact Count approach to health improvement.
MIAA	Mersey Internal Audit Agency.
MRG	Mortality Review Group.
MTS	Manchester Triage Score.
MUST	Malnutrition Universal Screening Tool.
NATSSIPs	National Safety Standards for Invasive Procedures.
NCEPOD	National Confidential Enquiry into Patient Outcome and Death.
NEWS2	National Early Warning Score 2.
NHSE	NHS England.
NIHR	National Institute for Health and Care Research.
NRLS	National Reporting and Learning System (superseded by LFPSE).
PALS	Patient Advice and Liaison Service.
PCN	Primary Care Network.
PHSO	Parliamentary and Health Service Ombudsman.
PI	Principal Investigator responsible for research delivery.
PMRT	Perinatal Mortality Review Tool.
POMH	Prescribing Observatory for Mental Health.
PRES	Participant Research Experience Survey.
PROMs	Patient Reported Outcome Measures, capturing patient-reported health outcomes following treatment.
PSII	Patient Safety Incident Investigation.
PSIRF	Patient Safety Incident Response Framework, replacing previous investigation frameworks.
PSSG	Patient Safety Steering Group.
Quality Account	An annual public report describing the quality of NHS services provided, priorities for improvement, and assurance statements.

Abbreviations	Definitions
QAC	Quality Assurance Committee.
QCOG	Quality Compliance Oversight Group.
RD&I	Research, Development and Innovation.
SACT	Systemic Anti-Cancer Therapy.
SDEC	Same Day Emergency Care.
SHMI	Summary Hospital-level Mortality Indicator.
SIRO	Senior Information Risk Owner.
SJR	Structured Judgement Review methodology for mortality review.
SOP	Standard Operating Procedure.
SUS	Secondary Uses Service.
TEDS	Thrombo-Embolus Deterrent Stockings.
UEC	Urgent and Emergency Care.
UKHSA	UK Health Security Agency.
VFC	Virtual Fracture Clinic.
VTE	Venous Thromboembolism.
WHH	Warrington and Halton Teaching Hospitals NHS Foundation Trust.

Annex 5: How to provide feedback.

We would like to hear your views on our Quality Account

The Quality Account gives the Trust the opportunity to tell you about the quality of services we deliver to our patients. We would like your views to help shape our report so that it contains information, which is meaningful to you and reflects, in part, the aspects of quality that matters most to you.

If you have any feedback regarding the Quality Account, please e-mail your comments to: ncm.qualityaccount@nhs.net

However, if you prefer pen and paper, your comments are welcome at the following address:

Write to:

Integrated Governance and Quality Team
Governance Office
Kendrick Wing
Warrington Hospital
North Cheshire and Mersey NHS Foundation Trust
Lovely Lane
Warrington, WA5 1QG

Annex 6: Other formats and Quality Accounts Availability

This document can also be made available in various languages and different formats including Braille, audio tape and large print.

Additional copies of the Quality Account can also be downloaded from the Trust website:

North Cheshire and Mersey NHS Foundation Trust - Annual Reports and Quality Accounts

Our website

The Trust's website gives more information about the Trust and the quality of our services. You can also sign up as a Trust member, read our magazine or view our latest news and performance information via: North Cheshire and Mersey NHS Foundation Trust - North Cheshire and Mersey NHS Foundation Trust

For more information, you can contact the Communications and Engagement Team:

Call:	(01925) 662873
Email:	ncm.communications@nhs.net
Write to:	Communications and Engagement Team Communications Office Warrington Hospital North Cheshire and Mersey NHS Foundation Trust Lovely Lane Warrington, WA5 1QG